

## Notice of Privacy Practices (HIPAA) Acknowledgment

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I, \_\_\_\_\_ have received a copy of Notice of Privacy Practices.  
Name of client or personal representative

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
Date

Or

\_\_\_\_\_  
Signature of client's personal representative

\_\_\_\_\_  
Date

**If signed by a personal representative, state your relationship to patient and/or reason and legal authority for signing below.**

Client is:  minor  incompetent  disabled  deceased

Legal authority is:  parent  legal guardian  next of kin of deceased

**This Notice of Privacy Practices was given by:**

face to face meeting  mail  email  other

**Reason Individual or Personal Representative did not sign this form:**

Individual or Personal Representative chose not to sign

Individual or Personal Representative did not respond after more than one attempt

Email receipt verification

Other \_\_\_\_\_

**Good Faith Efforts:** The following good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature. Please document with detail dates/s, time/s, individual/s spoken to and outcome of attempts, the efforts that were made to obtain the signature. More than one attempt must have been made.

Face to face presentation/s \_\_\_\_\_

Telephone contact/s \_\_\_\_\_

Mailing/s \_\_\_\_\_

Email \_\_\_\_\_

Other \_\_\_\_\_

**Staff or Clinician Signature:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

