

# Advanced Surgical Associates

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement of receipt but we must keep a record of your refusal. If you refuse to sign this acknowledgement of receipt, we are required to treat you and we may still use and/or disclose your health information as HIPAA permits.

I acknowledge that I have received a copy of this office's Notice of Privacy practices.

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement or receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The patient refused to sign
- Due to an emergency situation it was not possible to obtain acknowledgement
- We were unable to communicate with the patient
- Other (provide specific details)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date

HIPAA Acknowledgement of receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state law.