



## Acknowledgement of Receipt of Notice of Privacy Practices

*This form will be retained in your medical record.*

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### NOTICE TO PATIENT

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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.

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

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Elevate Sport and Spine Center**

I understand that the Notice describes the uses and disclosures of my protected health information by **Elevate Sport and Spine Center** and informs me of my rights with respect to my protected health information. **Elevate Sport and Spine Center** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice upon request.

\_\_\_\_\_  
*Patient's Signature or that of Legal Representative*

\_\_\_\_\_  
*Printed Name of Patient or that of Legal Representative*

\_\_\_\_\_  
*Today's Date*

\_\_\_\_\_  
*If Legal Representative, Indicate Relationship*

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### FOR OFFICE USE ONLY

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We have made every effort to obtain written acknowledgment of 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 an acknowledgement
  - Communications barriers prohibited obtaining the acknowledgement
  - Other (please specify): \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_  
*Employee Name*

\_\_\_\_\_  
*Today's Date*