

# HIPPA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgment Form

Robert B. Cole, MD – Timothy A. Leach, MD

## Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I, \_\_\_\_\_ (Patient's Name) understand that as part of my health care, Robert B. Cole, MD and Timothy A. Leach, MD originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Robert B. Cole, MD and Timothy A. Leach, MD **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review Robert B. Cole, MD and Timothy A. Leach, MD Notice of Privacy Practices prior to signing this acknowledgement;
- that Robert B. Cole, MD and Timothy A. Leach, MD reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual \_\_\_\_\_  
Printed Name of Individual \_\_\_\_\_  
Date: \_\_\_\_\_

### FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Others (please specify)

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\_\_\_\_\_  
Ms. Jamie A. Rackley  
Privacy Official

\_\_\_\_\_  
Date