Acknowledgment of Receipt for the Notice Regarding Privacy Practices

Federal Law "Health Insurance Portability and Accountability Act" (HIPAA) mandates that you shall be notified regarding the privacy and confidentiality practices of the institution and that an acknowledgment of receipt be obtained. This law requires that, in order to provide you our services, we must obtain your authorization (*consent,* according to HIPAA) for using and disclosing your protected health information for treatment, payment and other healthcare transactions or operations carried out by our organization.

So that we may comply with the pertinent legal provisions, our entity has notified you the ***"Notice Regarding Privacy Practices"*** and hereby requests you to sign this Acknowledgment of Receipt as evidence that we have notified you of said Notice and your authorization to use and disclose your health information for treatment, payment and other healthcare operations. You also authorize that the organization, its staff (including the employees, volunteers, etc.) and its business associates may use and disclose your protected health information for treatment, payment and other healthcare transactions and operations.

By signing, you acknowledge having been notified regarding your *Privacy Practices* and you consent to the use and disclosure of your health information, as described in the Notice. Please examine it carefully, sign it and write the date where indicated.

Lastly, please remember that the organization reserves the right to review, change or amend the policy or practice regarding the use and disclosure described in the Notice, at any moment. If you would like an updated copy of the Notice, please contact the Privacy Officer at the phone numbers indicated herein.

I, ____, hereby certify that I have read the provisions included in the "***Notice Regarding Privacy Practices***", that I understand it and agree with the terms and conditions set forth therein and that I also give my consent and authorization for the use and disclosure of my health information for treatment, payment and other healthcare transactions and operations regarding my healthcare, as legally defined.

Patient's Name (please print by hand)	Record Number
Patient's Signature or Mark	Date
Authorized Representative's Name (if applicable)	Representative's Signature (if applicable)
Relationship with Patient	Date

Only for Official Use

After reasonable efforts to obtain the Acknowledgment of Receipt for the Notice Regarding Privacy Practices and Consent, we were not able to obtain it due to:

- ☐ Patient refused to sign the Acknowledgment of Receipt
- ☐ Language barrier
- ☐ Other (please explain)

Employee's Name (please print by hand)	Employee's Signature	Date

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