

## 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:** \_\_\_\_\_

