# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
# GRACE MEDICAL OF TROY

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, if you wish.

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

Please print your name

Signature Date

**Authorized personnel to discuss health information.**

Name of individuals and Phone Number:

FOR GRACE MEDICAL OF TROY USE ONLY

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 acknowledgment
We weren't able to communicate with the patient
Other (Please 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**