

**Sample Form of Patients' Acknowledgment of Receipt of
Notice of Privacy Practices*¹**

Insert Practice Letterhead

Patient Name: _____ **Birth date:** _____
Maiden or other name (if applicable): _____

I acknowledge that I have received a copy of the Notice of Privacy Practices of [Name of practice/group/facility], effective [insert date of Notice currently in effect].

Signature (patient or authorized representative): _____

Date: _____

Relationship/authority (if signed by authorized representative):

**Note: The text contained on this form could be added to the end of your Notice of Privacy Practices, and then signed, detached, and filed once a patient has reviewed your Notice.*

¹ **Disclaimer:** This information is provided to assist APA members in complying with the federal HIPAA privacy regulation. Members should use this information to draft policies and procedures that fit their particular practices. This information is provided solely for general informational purposes and does not constitute, and should not be relied upon as, legal advice. Members should consult with attorneys to evaluate their specific circumstances and obtain customized advice, particularly with respect to drafting policies and procedures that comply with applicable state law which may, in certain cases, preempt the federal law requirements. While all reasonable attempts have been made to ensure the accuracy, completeness, and timeliness of this information, the APA disclaims any express or implied representations or warranties as to the accuracy, completeness or timeliness of this information for any purpose or suitability of this information for any particular use. Members using this information assume full responsibility for their use of it and agree that the APA is not liable for any claim, loss or damage arising from any member's use or reliance upon this information.