ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I have received a copy of the Notice of Privacy Practices. I understand this notice explains how my protected health information is used and disclosed by the practice, and my rights regarding my protected health information.

I understand I should keep the Notice and refer to it if I have questions. I also understand I should contact the Compliance at compliance@sdbmail.com if I have a question or concern about my privacy rights.

_____

Printed Name of Patient

_____ _____

(If applicable) Printed Name of Patient's Legal Representative **Relationship to Patient**

_____ _____

Signature of Patient or Patient's Legal Representative **Date**

FOR OFFICE USE ONLY IF ACKNOWLEDGEMENT IS NOT SIGNED

The following attempt(s) were made to obtain a written Acknowledgement of Receipt:

□ NPP given to the patient who refused to sign.

□ NPP was mailed to the patient's home address as stated in record.

□ NPP was mailed to an alternate address at the patient's request.

□ NPP was faxed or e-mailed to the patient at their request.

Other reason(s) why written acknowledgement was not obtained: _____

_____

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