ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

OAKSTONE HEALTH CENTER

You may refuse to sign this Acknowledgement

I _____, have received a copy of this office's Notice
(Please Print Your Name)

of Privacy Practices and have been provided an opportunity to review it.

Name of Patient: _____ Patient's Date of Birth: _____

_____ _____

Signature of Patient or Parent, Guardian or Personal Representative Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please specify)