FLOWER MOUND
FAMILY PHYSICIANS

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

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 of Privacy Practices. You may refuse to sign this acknowledgment if you wish.

Acknowledgment:

I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____/_____/_____
Patient Name Date of Birth

_____ _____/_____/_____
Signature of patient or patient's legal representative Date

_____
Relationship to Patient

For Office Use Only:

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices from the individual noted above, but it could not be obtained because:

An emergency prevented us from obtaining acknowledgement.
A communication barrier prevented us from obtaining acknowledgement.
The individual was unwilling to sign.

Other: _____

_____

STAFF MEMBER SIGNATURE: _____ DATE: _____