



Acknowledgement of Health Information Privacy Practices Notice

Today's Date: _____

Patient Name: _____

Patient Date of Birth: _____

Please circle correct answer:

I do / do not have a private voice mail where you can leave private health information. The number of that voice mail is: _____ or _____.

Please note that even if you have given us permission, if we cannot ascertain that the voice mail is private, we will not leave detailed messages. We will however leave appointment confirmation messages on the number that you designate as your home number regardless of your choice above.

You may leave or discuss private information with the following individuals:

Person's Name	Relationship to Patient

I acknowledge that I have reviewed Provident Healthcare's *Notice of Privacy Practices*.

Patient Signature: _____

If patient is under the age of 16, Parent or Guardian Signature: _____

Office use Only:

I attest that I attempted to obtain the patient's signature on this form and was unable to due to the reason stated below. By initialing below, I affirm that the patient was made aware of the *Notice of Privacy Practices*.

Date: _____ Initials: _____

Reason: _____

Internal Routing: ___ updated EPM chart scan into "HIPAA" section of chart