HIPAA Acknowledgement
Notice of Privacy Practices

Printed Name of Patient _____

Patient Date of Birth _____

I acknowledge receipt of Advocare's Notice of Privacy Practices.

Signature of Patient/Legal Representative

_____ Date: _____

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Office Use:

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained.

Reason: _____

Signature of Advocare Representative: _____

Printed Name: _____ Date: _____