

Physical Therapy Center

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ACKNOWLEDGEMENT OF RECEIPT 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 discuss our health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices

X _____

Please print your name here

X _____

Signature

X _____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

___ The patient refused to sign

___ Due to an emergency situation it was not possible to obtain an acknowledgment

___ We weren't able to communicate with the patient

___ Other (please provide specific details):

Employee Signature

Date

HIPPA Acknowledgement of the Notice of Privacy Practices

This form does not contribute legal advice and covers only federal, not state law.