



Acknowledgment of Receipt of Notice of Privacy Practices (NOPP)

By signing below I acknowledge that I have been provided a copy of the Notice of Privacy Practices (NOPP). I have therefore been advised of how health information about me may be used and disclosed by the hospitals and facilities listed in the beginning of this notice as well as how I may obtain access to and control over this information.

Last Name	First Name	MI
Date of Birth	Signature of patient or authorized representative	
Name of authorized representative	Relationship to patient	
Date		

FOR OFFICE USE ONLY

I was not able to obtain the patient's acknowledgment of receipt of the NOPP upon registration because:

- The patient refused to sign despite good faith efforts
- The patient was unaccompanied and not alert and oriented
- The patient was unaccompanied and needed emergency care
- Other, (explain):

Employee name	Date
Employee signature	Employee title

- Acknowledgment subsequently obtained, (see above).