Patient Receipt of HIPAA Privacy Notice

(Name of Patient)_____

By signing below, I acknowledge receiving a copy of the "Privacy Notice" of the medical practice designated above, describing my right to privacy of my protected health information (PHI) under the Federal HIPAA Privacy Law, as follows:

- **How the patients' PHI may be used and disclosed,**
- **Patient privacy rights regarding PHI,**
- **The medical practice's obligations concerning the use and disclosure of my PHI.**

Signed (Patient or Parent/Guardian):_____

Signed (Witness):_____ (Date)_____

(Original of this form to be filed in Patient's chart after signing.)