117A Tradewynd Dr.
Lynchburg, VA 24502
Phone 434-533-1660
Fax 866-201-2808

ACKNOWLEDGMENT 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.

The notice states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of the Notice.

You may refuse to sign this acknowledgment, if you wish.

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

_____	_____
Please print your name here	Guardian Please print name here
_____	_____
Signature	Signature
_____	_____
Date	Date

FOR OFFICE USE ONLY
We have made every effort to obtain written acknowledgment 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