HIPPA ACKNOWLEDGEMENT FORM

Integrated Health Services

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information.

Please sign this form to acknowledge that you have been made aware of this policy.

I acknowledge that I have been made aware that the Notice of Privacy Practices is available for my review.

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Print your name:

____

Signature:

____

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:

- Patient refused to sign
- Due to an emergency situation it was not possible to obtain an acknowledgement
- We were not able to communicate with the patient
- Other (please provide specific details)

________________________	____________________
EMPLOYEE SIGNATURE	DATE