



2865 WEST RD, TRENTON MI 48183 | PHONE (734) 992-5252

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(please print)

### Acknowledgment of notice of privacy practices

**I acknowledge:**

A copy of the provider's notice of privacy practices was made available to me at the place where I went for health care services. A copy of the notice of privacy practices was made available for me to review and a copy provided per my request.

If I came in for health care services in an emergency situation, I was able to view the notice as soon as reasonably possible after the emergency situation.

Signature of patient or patient's representative: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### **For Office Use Only:**

If an acknowledgment is not obtained, document below provider's good faith efforts to obtain the acknowledgment and the reason why the acknowledgment was not obtained:

Individual's name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason Acknowledgment was not obtained: please check one.

1. Individual declined to sign.
2. Individual stated that he/she has already received a copy.
3. Individual arrived under emergency circumstances
4. Individual was not present to sign
5. Others: \_\_\_\_\_

\_\_\_\_\_  
Signature of workforce member: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_