



Acknowledgement of Notice of Privacy Practices

Patient Name: _____

Date of Birth: _____

I acknowledge that a copy of the current Notice of Privacy Practice will be available for me in the reception area. I acknowledge that the office of Dr. Stephen J. Franzino abides by HIPPA guide lines to ensure Privacy Practices. I acknowledge that I will be offered a copy of any amended Notice of Privacy Practice.

OR

Signature of Patient

Parent/Legal Guardian/Authorized Person

Relationship to Patient: _____

Date

Office Use Only:

If unable to obtain a written acknowledgement of receipt of NOPP from Patient

I have made a good faith effort to obtain a written acknowledgement of receipt of the **Notice of Privacy Practice** from the above named patient, but was unable to for the following reasons:

- _____ Language Barrier
- _____ Patient Cannot Read
- _____ Patient Objects
- _____ Unable to Sign
- _____ Other: _____

Employee Name

Date

Privacy Officer: Maricela Toscano

Please Continue To Next Page