ST. HELENA
Sports Medicine
& ORTHOPAEDICS

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 Sing
_____Other: _____

_____ _____
Employee Name Date

Privacy Officer: Maricela Toscano

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