

# HIGHER GROUND HEALING

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices for [name of your practice].

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_\_\_

\_\_\_\_\_

Signature of individual or legal representative

Date

\_\_\_\_\_

\_\_\_\_\_

Printed Name of person signing

Relationship to Client

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### FOR OFFICE USE ONLY

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We attempted to obtain written acknowledgement of receipt of our HIPAA Notice of Privacy Practices, but acknowledgement could not be obtained because:

\_\_\_\_ Individual refused to sign

\_\_\_\_ Communication barriers prohibited obtaining the acknowledgement

\_\_\_\_ An emergency situation prevents us from obtaining acknowledgement

\_\_\_\_ Other (Specify) \_\_\_\_\_

Dates attempted and what attempts were made I and by whom: \_\_\_\_\_

\_\_\_\_\_

