

# Notice of Privacy Practices Receipt of Acknowledgement and Signature Verification Form

This form acknowledges that this patient of Longs Peak Family Practice has received a copy of this clinic's HIPAA Privacy Policies. You may refuse to sign this acknowledgement.

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

In the case of records requested by, and/or for myself, this form also acts as a signature verification form.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient

\_\_\_\_\_  
LPFP Representative Witness Signature

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## For Office Use Only

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Our office has made a good faith effort in attempting to obtain written acknowledgement of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

Patient/Patient's representative refused to sign. Date of refusal: \_\_\_\_\_

Communication barriers prohibited obtaining an acknowledgement.

An emergency situation prevented us from obtaining an acknowledgement.

Other \_\_\_\_\_

Attempt was made by: \_\_\_\_\_ Date: \_\_\_\_\_