



128 W. 14th St., Suite B-2, Durango, CO 81301 970-422-7334

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____, have received a copy of this office's notice of privacy practices.

Patient name(s): _____

Signature: _____ Date: _____

Signature: _____ Date: _____

It is your right to refuse to sign this document.

FOR OFFICE USE ONLY:

The reason that a standard acknowledgment (such as the above) of the receipt of the notice of privacy practices was not obtained:

____ Patient refused to sign

____ Communication barriers prohibited obtaining the acknowledgment.

____ An emergency situation prevented this office from obtaining it.

____ Others: _____