

PHOENIXVILLE HEALTHCARE ACCESS FOUNDATION (HCA)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name (Please Print)

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of Health Care Access's Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

If you have any questions regarding the Health Care Access Notice of Privacy Practices, please let us know.

I acknowledge receipt of the Health Care Access Notice of Privacy Practices.

Signature of Patient/Parent/Guardian/Personal Representative

Date

For office use only

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Attempts have been made to obtain written acknowledgement of receipt of the Health Care Access Notice of Privacy Practices, but acknowledgement could not be obtained because:

- * Individual refused to sign
- * Barrier(s) to communication prohibited obtaining the acknowledgement
- * An emergency situation prevented us from obtaining the acknowledgement
- * Other (Please specify)

Signature of Provider Representative

Date: