HEALTH CARE ACCESS
100 First Avenue, 1st Floor, P. O. Box 591, Phoenixville PA 19460

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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Patient Name (Please Print)

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge you were offered a copy 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 I was offered a copy of or receipt of the Health Care Access Notice of Privacy Practices.

_____ _____
Signature of Patient/Parent/Guardian/Personal Representative Date

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For office use only

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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)

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_____ _____
Signature of Provider Representative Date