NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge that I have reviewed the Notice of Privacy Practices, which contains a description of the uses and disclosures of my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request. A current notice of privacy practices can be found by visiting: http://www.icmsvh.org/websiteprivacypolicy.html

Signature is valid for 365 days from date of patient signature.

Patient Name:_____

Signature:_____ **Date:**_____

Personal Representative (Required is patient is an adult unable to sign)

Name of Personal Representative:_____

Relationship to Patient:_____

Signature:_____ **Date:**_____

========== **OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement of receiving the Notice of Privacy Practices, but was unable to do so as documented below:

- □ Individual refused to sign
- □ An emergency situation prevented me from obtaining the acknowledgement
- □ Other (Please Specify):_____

Name of Office Staff:_____

Signature:_____ **Date:**_____