[Insert Name of Practice]	
SECTION A: The Patient	
Name:	
Address:	
Telephone:	E-mail:
Patient Number:	Social Security Number:
SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.	
I,Privacy Practices from the above-named practice.	, acknowledge that I have received a Notice of
Signature:	Date:
If a personal representative signs this authorization on behalf of the individual, complete the following:	
Personal Representative's Name:	
Relationship to Individual:	
SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.	
Describe your good faith effort to obtain the individual's signature on this form:	
Describe the reason why the individual would not sign this form:	
SIGNATURE. I attest that the above information is correct.	
Signature:	Date:
Print name:	Title:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE @ Michael Best & Friedrich, LLC