

Community Care

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES

I, (print name of patient) \_\_\_\_\_, acknowledge and agree that I have received a copy of Community Care's HIPAA Notice of Privacy Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Legal Representative (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Legal Representative

\_\_\_\_\_  
Relationship to Patient

**For Clinic Use Only:**

Community Care has made the following good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the HIPAA Notice of Privacy Practices:

(Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.)

Effective Date: January 1, 2005