Notice of Privacy Practices
Acknowledgement of Receipt

Today’s Date: __________________

I acknowledge that I was provided with a copy of the Baylor University Notice of Privacy Practices for Health Services and Clinics.

__________________________________  _________________________________
Patient Name (Print)     Patient Signature

If completed by a patient’s personal representative (e.g., parent or legal guardian), please print and sign your name in the space below.

__________________________________  _________________________________
Personal Representative (Print)   Personal Representative Signature

_________________________________
Relationship

For Baylor University use only

Complete this section if this form is not signed and dated by the patient or patient’s personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices but was unable to for the following reason:

□ Patient refused to sign
□ Patient unable to sign
□ Other: _______________________

__________________________________  _________________________________
Employee Name      Date

This form should be placed in the patient’s record.