

## Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have been offered a copy of the practice's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of health care operations. The Notice of Privacy Practices also describes my rights and the provider's duties with respect to my protected health information. The Notice of Privacy Practices is posted in Arlington, VA office and on the website at [www.infinitetech.org](http://www.infinitetech.org).

The office reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or accessing the practice's website.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
We have attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices but were unable due to:

- \_\_\_\_\_ Individual refused to sign
- \_\_\_\_\_ Patient unable to sign due to physical ailment
- \_\_\_\_\_ Communication barriers, no translator available
- \_\_\_\_\_ Patient unconscious (Post-op ventilator, etc)
- \_\_\_\_\_ Patient is a minor, no legal representative available
- \_\_\_\_\_ Other: \_\_\_\_\_