**Acknowledgement of Receipt of Notice of Privacy Practices**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIPPA – Notice of Privacy Practices

* I have been provided with a copy of Notice of Privacy Practices
* I know that the Notice may be changed at any time.
* I may get a new copy of the notice by writing to the Privacy Official, Genesis Neuroscience, 1400 Dowell Springs, Suite 340, Knoxville, TN 37909

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Patient’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Authorized Person Date

**For staff use only:**

\_\_\_\_Patient refused to sign. Patient was informed that signing merely acknowledges that the Notice has been made available to the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Staff Date