RANDALL F. HUMPHREYS, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have read a copy of this office's Notice of Privacy Practices which is attached to the clipboard. A copy of the Privacy Practice is available at my request.

Print Name _____

Signature _____

Date _____/_____/_____

Patient's Name if different from above _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify) _____

_____

_____

A copy of your Clinical Summary is available upon request within 3 days of your visit.