**Notice of Privacy Practices Acknowledgement of Receipt**

The Notice of Privacy Practices provides information about how protected health
information about you may be used and disclosed.

In addition to the copy that has been provided for you, copies of the current notice are
available by accessing the website www.DanielBartonMD.com. In addition, you may
request additional copies from this office.

**I acknowledge that I have received the Notice of Privacy Practices. I have read or
will read it in the near future, and am responsible for knowing its contents.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Patient or Patient's Representative

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

Print Name

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

Signature of Observing Individual (Dr. Barton or a Representative)

 Date

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

Relationship If
Other than Self

 Patient provided signature but refused to take physical copy of Notice of Privacy

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

Staff signature and date

 Patient refused to provide signature for acknowledging receipt of Notice of Privacy Practices

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

Staff signature and date

 Patient was incapacitated and unable to provide signature for acknowledging receipt of

 Notice of Privacy Practices

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Staff signature and date