Valley Regional Sleep Disorders Center

AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of Valley Regional Sleep Disorders Center's Notice of Privacy Practices.

____
Please print your name here

____
Signature Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.
☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
☐ We were unable to communicate with the patient.
☐ Other (please provide specific details)

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Employee's Signature Date

HIPAA Acknowledgement of Receipt of Privacy Practices
This form does not constitute legal advance of covers only Federal, not State laws.