# Notice of Privacy Practices Acknowledgement

## Butler County Clinic, PC & Butler County Health Care Center

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name (Print): _____ DOB: _____

Signature: _____ Date: _____

If patient unable to sign, please print name and relationship to patient below.

Signed by: _____

Relationship to Patient: _____

For office Use only:

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: _____

Attempt: _____

Staff Signature: _____