

Drs. Bonner, Schaible & O'Grodnick

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practice or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I _____ have received a copy of this
office's Notice of Privacy Practices.

Print Name: _____

Sign: _____

Date: _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I, _____
authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

{Please Print Name} Relationship

{Please Print Name} Relationship

{Please Print Name} Relationship

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____

