Life Restoration SOULutions

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____

I hereby acknowledge that I have received a copy of Life Restoration SOULutions, PLLC's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

______________________________________ ____________________________________
Signature of Patient or Legal Representative Date

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Printed Name of Patient's Representative (if applicable)
(Please circle appropriate description)
Relationship to Patient (if applicable)
Parent or guardian of unemancipated minor
Court appointed guardian
Executor or administrator of decedent's estate
Power of Attorney

- -

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _______________________________, but acknowledgment could not be obtained because:
Patient/representative refused to sign
Emergency situation prevented us from obtaining acknowledgement at this time
(will attempt again at a later date)
Communication barriers prohibited obtaining acknowledgement (Explain)

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Other (Specify)

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