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AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____ **DOB**: _____

Our commitment to your privacy at Glacier Bay Medical and Diabetes Care Center

We are required by law to maintain the privacy of Protected Health Information and to maintain the privacy of your individually identifiable health information and to give you this notice explaining our privacy practices with regard to that information.

By signing this form, you acknowledge that Glacier Bay Medical and Diabetes Care Center has made an available copy to you of its Notice of Privacy Practices, which explains how your health information will be handled. The Health Insurance Portability and Accountability Act (HIPAA), the Federal Law concerning Medical Privacy, requires this notice.

I have read the Notice of Privacy Practices. Glacier Bay Medical and Diabetes Care Center has given me the opportunity to ask any questions about this notice, and all my questions have been answered.

_____ _____

Signature of Patient or Patient Representative **Date**

Office use only

If the patient was not able, or did not want to sign, please document if the patient was given the notice and reason why the patient did not sign below.

Patient was given the notice: _____ Yes _____ No

Reason signature was not obtained:

Staff Signature: _____

Date: _____