



Well Baby Center®
Notice of Privacy Practices
Health Insurance Portability and Accountability Act (HIPAA)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, (Name of Client or Parent of Client) _____ have received a copy of this office's notice of privacy practices.

Client Name: _____

Signature: _____ Date: _____

It is your right to refuse to sign this document.

FOR OFFICE USE ONLY:

The reason that the above HIPAA Acknowledgment of the Receipt of the Notice of Privacy Practices was not obtained is as follows:

____ Patient refused to sign.

____ Communication barriers prohibited obtaining the Acknowledgement.

____ An emergency situation prevented this office from obtaining it.

____ Other: _____