

# Acknowledgement of Receipt of Notice Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices of Lifescope Medical Associates, PC, which explains its legal duties and privacy practices with respect to my protected health information. I understand that I may refuse to sign this acknowledgement.

\_\_\_\_\_  
Signature of the Patient or the Patient's Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient

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## FOR OFFICIAL USE ONLY

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I, \_\_\_\_\_, made a good faith effort to obtain written acknowledgement of \_\_\_\_\_'s receipt of the Notice of Privacy Practices of LifeScape Medical Associates, PC However, I could not obtain written acknowledgement because:

- Individual refused to sign this Acknowledgement
- Communications barrier prohibited obtaining written acknowledgement
- An emergency situation prevented obtaining written acknowledgement
- Other (please specify) \_\_\_\_\_

\_\_\_\_\_  
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