

# Douglas C. Brown, M.D., FACS

## Acknowledgement of Receipt of Notice of Health Information Privacy Practices

I, (patient name) \_\_\_\_\_, acknowledge receipt of this **Notice of Health Information Privacy Practices**.

I, \_\_\_\_\_, certify that I have made a good faith effort to obtain written acknowledgement of receipt of this **Notice of Health Information Privacy Practices**, from patient \_\_\_\_\_ but the acknowledgement was not obtained because:

---

---

---

---

By: \_\_\_\_\_

This \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

**This document must remain in the patient's chart at all times.**

This document must be retained for the longer of 6 years from the date of its creation or when it was last in effect.