

# Acknowledgement of Receipt of Notice of Privacy Practices

I, \_\_\_\_\_, have received the  
(Please Print Patient Name)

Notice of Privacy Practices from Tri-Area Community Health, Inc. at  
Laurel Fork, Ferrum, and Floyd.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OR**

in lieu of patient signature, I, \_\_\_\_\_,  
(Please Print Your Name)

a staff member of Tri-Area Community Health state that

\_\_\_\_\_ has been given our  
(Please Print Patient Name)

current Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(FILE IN PATIENT MEDICAL RECORD)

\_\_\_\_\_  
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