



ACKNOWLEDGMENT OF RECEIPT of the
Notice of Privacy Practices of
Emmitsburg Osteopathic Primary Care Center, Inc.

I, _____, acknowledge that I have received or been offered the HIPAA Notice of Privacy Practices for Emmitsburg Osteopathic Primary Care Center, Inc., required by the 1996 Federal Health Privacy Act.

I understand that the Notice of Privacy Practices for Emmitsburg Osteopathic Primary Care Center, Inc. contains a more complete description of the uses and disclosures of my protected health information.

I understand that this healthcare office has the right to change its Notice of Privacy Practices from time to time and that I may contact this healthcare office at any time at the address below to obtain a current copy of the Notice of Privacy Practices or to discuss additional concerns.

Privacy Officer
EOPCC
P.O. Box 1219
Emmitsburg, MD 21727

Name of Patient

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Printed Name of Patient or Personal Representative

Declinations

- _____ The Individual declined to accept a copy of the Notice of Privacy Practices.
- _____ The Individual received a copy of the Notice of Privacy Practices but declined to sign an Acknowledgement of Receipt.
- _____ Other *(please provide specific details)* _____

Signature of EOPCC Representative

Name of EOPCC Representative