



6041 Village Dr. Ste 110  
Lincoln, NE 68516-5774

### Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name or Legal Guardian of Minor/POA/HCP/A (Print)      Relationship to Patient

\_\_\_\_\_  
Signature      Date

*Office Use Only*

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: \_\_\_\_\_ Attempt: \_\_\_\_\_

Staff Name: \_\_\_\_\_

*Faint, illegible text or stamp in the bottom right corner.*