

Acknowledgement of Receipt of Notice of Privacy Practices

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| Patient Name: | Patient ID #: |
|---------------|---------------|

I hereby acknowledge that I have received a copy of Heart Partners of Indiana, LLC Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

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|--|--|
| _____ Signature of Patient or Legal Representative | _____ Date |
| _____ Printed Name of Patient's Representative (If applicable) | Relationship to Patient (if applicable) <input type="checkbox"/> Parent or guardian of unemancipated minor <input type="checkbox"/> Court appointed guardian <input type="checkbox"/> Executor or administrator of decedent's estate <input type="checkbox"/> Power of Attorney |

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____ but acknowledgement could not be obtained because:

- Patient/representative refused to sign
- Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- Communication barriers prohibited obtaining acknowledgement (Explain)

- Other (Specify)
