High Rock Internal Medicine, P.A.
Patient Acknowledgement of Receipt of
Notice of Privacy Practices (NPP)
Version 130905 1139

I, _____ hereby affirm that I have received a copy of the *Notice of Privacy Practices, Version 130905 1139,* from High Rock Internal Medicine, P.A.. Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if applicable)

▼▼▼ FOR OFFICE USE ONLY-Staff Complete Each of the 4 Lines ▼▼▼

Staff received by:	
Date received by staff:	Time Received by staff:
Patient declined ☐ Patient did not decline ☐	If declined, Staff Signature that witnessed the decline. _____
Staff Signature of person setting Practice Advisory for 1 year renewal of NPP Form:	