Capital Primary Care
Acknowledgement of Receipt of Notice of Privacy Practices

By signing this fom1, you acknowledge the Capital Primary Care has given you a copy of its Notice of Privacy Practices. This notice explains how your health information, will be handled, HIPAA, the federal law concerning medical privacy.

I have received a copy of the Notice of Privacy Practices. Capital Primary Care has given me the opportunity to ask questions about the notice, and all my questions have been answered.

Patient's Name Printed

Patient or Guardian Signature

Date

Provider Use Only

If the Patient was not able to sign due to an emergency, or does not want to sign, please document if the patient was given the notice, and the reason whythe patient did not sign below.

Patient was given the notice_____Yes_____No

Reason signature was not obtained: _____