



2610 2<sup>nd</sup> Ave.  
Kearney, NE 68847

**Notice of Privacy Practices Acknowledgement**

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 or Guardian's Name (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

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

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

Signature: \_\_\_\_\_