



**Drs. Henzel and Smith, Inc.**

3940 Fulton Drive NW. Canton, Ohio 44718-3043

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**Acknowledgement of Receipt of Notice of Privacy Practices**

\* You May Refuse to Sign This Acknowledgment\*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**I acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment, and prognosis to the following individual(s):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**For Office Use Only**

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)