# NOTICE OF PRIVACY PRACTICES

## Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the **Notice of Privacy Practices** of

**Philip A. Robinson, M.D.**

Our **Notice of Privacy Practices** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our **Notice of Privacy Practices** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at (949) 650-9155.

I acknowledge receipt of the **Notice of Privacy Practices** of Philip A. Robinson, M.D.

Signature:_____ Date:_____
(patient/parent/conservator/guardian)

Print Name:_____

## For Office Use Only

### INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative:_____Date:_____

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (please Specify):

_____
_____
_____
_____
_____