



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Hudson Physicians' Notice of Privacy Practices. Hudson Physicians is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

By signing below, you are acknowledging that you have received a copy of Hudson Physicians Notice of Privacy Practices.

Printed Patient Name: _____

Printed Patient Representative Name: _____

Signature: _____ Date: _____

If signed by the Patient Representative, state authority to act on behalf of patient:

Hudson Physicians, S.C. Use Only

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason Acknowledgement was not obtained:

Signature: _____ Date: _____