Tallahassee Cancer Institute
1653 Mahan Center Blvd., Tallahassee, FL 32308
Tel: 850-219-8000 • Fax: 850-219-8003

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are requires to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign

☐ Due to an emergency situation, it was not possible to obtain an acknowledgement

☐ We were not able to communicate with the patient

☐ Other *(Please provide specific details)*

_____

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_____ _____

Employee Signature *Date*