

Dr. Rebecca E Hutchins, O.D., F.C.O.V.D.
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303.652.0505

Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that the office of Dr. Rebecca E. Hutchins and Associates has provided me with a copy of the Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Dr. Rebecca E. Hutchins and Associates
303-652-0505

I also understand that I am entitled to receive updates upon request if the office amends or changes their Notice of Privacy Practices in a material way.

Signature

Relationship to patient if signed
by someone other than the patient

Date

This section is to be completed if unable to obtain written acknowledgement from patient.

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to because:

____ Patient declined to sign this Written Acknowledgement
____ Other (specify): _____

Name and title of employee

Date