HealthSource Saginaw, Inc.

Health Insurance Portability and Accountability Act (HIPAA)

ACKNOWLEDGEMENT
RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received the Notice of Privacy Practices from HealthSource Saginaw, Inc.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

Documentation of Failure to Obtain Signed Acknowledgement

On _____HealthSource Saginaw, presented its Acknowledgement of Receipt of Notice of Privacy Practices Form to _____
The patient refused or was unable to provide a signature when requested.