CENTER FOR HEADACHE. TMJ, & SLEEP DISORDERS

3540 SOUTH POPLAR ST, SUITE 301
DENVER, CO 80237
303-758-2980

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient's Name _____ Date of Birth: _____

In coordination of HIPAA, our office will maintain privacy of our patients records, and will not distribute any PHI unless specifically requested from the patient.

I hereby acknowledge that I received the Notice of Privacy Practices (HIPPA).

I herby state that my records:

☐ Can be reviewed by my spouse or other person. Name: _____

☐ Cannot be reviewed by my spouse or another person.

_____ _____
Signature of Patient or Patient Representative Date

DOCUMENTATION OF GOOD FAITH EFFORTS

A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign because _____

☐ Other Reason

_____ _____
Signature of Employee Completing Form Date