Acknowledgement of Health Care Components Notice of Privacy Practices: Your Rights and Our Responsibilities

My signature below is to acknowledge that I have received, I have read or been offered a copy of the **“Your Rights and Our Responsibilities”** document that explains my privacy rights.

I have had the opportunity to ask questions about the document. My questions have been answered satisfactorily. If I have future questions or concerns, I can contact: Mark Orth MA/LP: 612-716-3925 or mark.orth@graymatterpartners.com

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Printed Name of Client (or legal Representative of client) *

Signature of Client (or legal Representative of client)

Date: ____ / ____ / _______

* Capacity or Authority of legal Representative May be requested to provide verification of representative status.

OFFICE USE ONLY

We have made efforts to obtain written acknowledgement of the Notice of Privacy Practices. However, acceptance could not be obtained due to the following:

__ Individual refused to sign. __ Communication barriers prohibited acknowledgement.
__ An emergency situation prevented acknowledgement. __ Other (please specify below)