VIVID HEALTH,PLLC

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. This Notice describes the types of uses and disclosures of my protected health information (PHI) that might occur in my treatment, payment of my bills, or in the performance of health care operations. This form will be filed in the patient's medical record.

_____	_____	_____
Printed Name	Date	Signed Name
_____	_____	_____
Legal Representative	Date	Description of Authority

Office Use Only

An attempt was made to obtain the patient's or legal representative's signature on this Acknowledgement but did not because:

_____ It was emergency treatment
_____ Inability to communicate with patient
_____ Patient refused to sign
_____ Patient was unable to sign due to _____
_____ Other _____

Signature of Privacy Officer _____