Rebecca Crandall, M.D.

Acknowledgement of Receipt of Notice of Privacy Practices

Section I

I, _____, acknowledge that the Notice of Privacy Practices that explains limits on ways that the Office of Dr. Rebecca Crandall may use or disclose my PHI for mental health and other psychiatric services that are being provided by the Office of Rebecca Crandall, M.D., Rebecca Crandall, M.D. or any employee or associate of the Office of Rebecca Crandall, M.D. is available to me via her website and that we discussed it during the initial appointment or a subsequent appointment for patients already in treatment previous to this document being generated. I asked all the pertinent questions and was advised that I can gain further information if required in future.

Signature: _____ Date: _____

Print Name: _____

If not signed by the patient, indicate relationship: _____

Note: legal guardians and conservators must show proof.

Section II

This section is to be completed only by Dr. Crandall or any employee or associate of the Office of Dr. Crandall.

The patient did receive a copy of the Notice of Privacy Practices, but did not sign this Acknowledgement of Receipt because:

_____ Patient left office before Acknowledgement could be signed.

_____ Patient does not wish to sign this form.

_____ Patient can not sign because: _____

The Patient did not receive a copy of the Notice of Privacy Practices because:

_____ Patient required emergency treatment.

_____ Patient declined the Notice and signing this Acknowledgement.

_____ Other: _____

Provider or Staff name: _____

Signature: _____ Date: _____