SOLE CARE
MOBILE PODIATRY
Phone: 480-247-6494
Fax: 480-247-6643

Acknowledgement of receipt of Information Practices Notices (164.520(a))

I, _____ (patient's name), understand that as part of my healthcare, Sole Care Mobile Podiatry, PLLC, originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Sole Care Mobile Podiatry, PLLC's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

1. I have the right to review Sole Care Mobile Podiatry, PLLC's Notice of Privacy Practices prior to signing this acknowledgement;
2. Sole Care Mobile Podiatry, PLLC reserves the right to change their Notice of Privacy Practices, and prior to implementation of this, will mail a copy of the revised notice to the address of the patient or patient representative if requested.

Signature of Individual or Legal Representative: _____

Printed Name of Individual or Legal Representative: _____

Witness: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Patient's legal representative was not available. An additional copy of this form was left with caregiver to have patient's representative complete and fax form to **480-247-6643**, or representative may choose to leave completed form with facility caregiver to be given to Sole Care Mobile Podiatry, PLLC. Patient's representative to be provided with a copy of HIPAA Patient Privacy Practices by fax or mail, or representative can view copy left on file with facility, upon request.
- ☐ Other (please specifiy):

_____

HIPAA Officer: _____

Date: _____