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## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I received a copy of this medical facility's Notice of Privacy Practices which describes how my protected health information may be used and disclosed, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Printed Name of Patient \_\_\_\_\_ DOB \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

Printed Name of Personal Representative \_\_\_\_\_

Signature of Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Description of Authority of Personal Representative \_\_\_\_\_

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**FOR OFFICE USE ONLY:**

All medical offices will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If the patient (or personal representative) is unwilling and or unable to sign this acknowledgement, the facility must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

**To be completed by medical facility if unable to obtain written acknowledgement from the patient.**

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient, but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement.
- We were not able to communicate with the patient.
- Other (Please provide specific details) \_\_\_\_\_

Does patient have a copy of the Privacy Notice?

Yes  No

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Date

**Scan in Patient Chart**