

ACKNOWLEDGEMENT FORM

A Joint Notice of Privacy Practices is provided to all patients. This Notice of Privacy Practices identifies : 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing, received a copy of the the Joint Notice of Privacy Practices (NPP), and is the patient or patient's representative.

Today's date _____

Name of Patient

Signature of Patient

Name of Patient's Personal Representative

Signature of Patient's Personal Representative

FOR INTERNAL USE ONLY

WITNESSED BY: _____ Version

Name of employee

Signature of employee

If applicable, reason patient's written acknowledgement could not be obtained:

____ Patient was unable to sign.

____ Patient refused to sign.

____ Other _____