Santa Rosa Medical Group

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: ____

Medical Record Number: ____________________ Social Security Number: ____________________

Date of Admission: __________________________ Notice Version (Date): ________________

Acknowledgement of receipt of Privacy Practices Notice

I, ____, acknowledge that I have received a Privacy Practices Notice from:

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: ______________________________ Date: ____________________________

☐ Notice has previously been distributed by another location in our OHCA (except for physicians):

List location that distributed the Joint Notice: ____________________________________

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: ____

Relationship to Individual: ____

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form: ______________________

____

____

Describe the reason why the individual would not sign this form: ________________________________

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____

SIGNATURE: (Hospital Representative)

I attest that the above information is correct.

Signature: __________________________________ Date: ______________________________

Print name: _________________________________ Title: ______________________________

Include this acknowledgement form in the individual's records.