I have been given a copy of this Office’s *Notice of Privacy Practices (“Notice*”), which describes how my health information is used and shared. I understand that this Office has the right to change this *Notice* at any time.

I am aware that I may obtain a current copy by contacting the Office’s HIPAA Compliance Officer Mary J. Heffernan, ARNP.

**By checking this box and typing my name below, I acknowledge that I have been provided with a copy of the *Notice of Privacy Practices:***

|  |  |
| --- | --- |
| Signature of Patient or Personal Representative |  |
| Name of Personal Representative (if applicable) |  |
| Date |  |

**For Facility Use Only: *Complete this section if you are unable to obtain a signature.***

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Describe the steps taken to obtain the resident’s (or personal representative’s) signature on the *Acknowledgement:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |  |
| --- | --- |
| Completed by |  |
| Signature of Facility Representative |  |
| Date |  |