Randolph Health
Medical
Group

Acknowledgement of Receipt of Privacy Notice

Patient Name: _____ **Date of Birth:** _____

I have been presented with a copy of the **Notice of Privacy Practices**, detailing how my information may be used and disclosed as permitted under federal and state law.

I understand the contents of the Notice of Privacy Practices:

Signed: _____ **Date:** _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____

Witnessed by (staff):_____ **Date:** _____

Complete this section only if there are individuals (spouse, children, friends, family) that you would like to list as persons whom you grant us permission to share your health information with, including information related to treatment, billing and healthcare operations.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Internal Use Only:

If unable to obtain acknowledgement of receipt of notice, please document the date and time the notice was presented to patient or patient's representative and sign below.

Presented on (date and time):_____

By (name and title):_____

[ ] The patient declined to sign the acknowledgement

[ ] The patient was undergoing emergency treatment

[ ] Other _____