Piedmont HEALTHCARE

DT0832

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES

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❑ I hereby acknowledge that I have received a copy of the Piedmont Providers' "Notice of Privacy Practices."

_____
Print Name of Patient

_____ _____ _____
Signature of Patient or Patient's Authorized Representative | Date | Time

As the Patient's Authorized Representative, my relationship with the Patient is:_____

The Patient is unable to sign because:_____

——— OR ———

CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGMENT

❑ I hereby certify that, as an employee or agent of the Piedmont Providers, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the Piedmont Providers' "Notice of Privacy Practices" in accordance with the policy titled "Provision of the Notice of Privacy Practices."

_____
Print Name of Employee/Agent and Department

_____ _____ _____
Signature of Employee/Agent | Date | Time

Reason(s) For Not Obtaining Acknowledgment:_____

_____

_____

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PATIENT LABEL