4990 Golden Gate Pkwy **Phone: (239) 692-8309**
Naples, FL 34116 **Fax: (239) 692-8504**

Notice of Privacy Practices Acknowledgement Form

Patient Name: ________________________________ Date of Bird: ________________________________

I have been presented with a copy of ____

Notice of Privacy Practices, detailing how my information may be used and disclosed as permitted under federal and states laws.

By signing below I acknowledge the receipt of Notice of Privacy Practices:

____ ____
Signature of Patient or Representative Date

____ ____
*Printed name if not signed by Patient *Relationship/Authority to Act on behalf of the Patient

*If not signed by the patient you must provide with a copy of the document of authority that makes you the patient's personal representative (i.e. Health Care Power of Attorney, Health Care Surrogate, Health Care Proxy, Guardia, etc.). We also need a copy of your driver's license.

For Internal Use Only:

If a written acknowledgement was not obtained from the patient or the patient's personal representative, the person responsible for obtaining the written acknowledgment must document the reason for failure below:

Reason: ____

____

Employee Name and Title: ____

Date: ____________________________

____

Please post the above information in the patient's coded/sticky notes under the coded note HIPAA.
Type the Date the form was signed in the HIPAA coded/sticky note.

Posted By: ____

This form and any personal representative documentation must be filed/scanned into the patient's medical record.

Revised June 16th, 2016.