ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that you received the Notice of Privacy Practices of the _______________________. The Notice tells you how we may use and disclose your protected health information. Copies of the current notice are also available on:

_________________________________________________________

Signature of Legal Decision Maker/Patient

Date

Print Name: (Last, First and M.I.)

Relationship to Patient

FOR OFFICE USE ONLY

If written acknowledgment is not obtained, please check the reason:

☐ Notice of Privacy Practice Given – Legal Decision Maker Unable to Sign
☐ Notice of Privacy Practice Given – Legal Decision Maker Declined to Sign
☐ Other: ___________________________________________________

INTERPRETER USE FOR LIMITED ENGLISH-PROFICIENT, DEAF OR HEAR OF HEARING

☐ A Clinic interpreter was used: Name of Interpreter: __________________________ Date: ________

Signature of In-Person Interpreter

Print Name or ID#/Company

☐ I do not want to use the clinic’s interpreter. __________________________ (Patient’s Signature)
☐ I prefer to use my family member to interpret. __________________________ (Patient’s Signature)

ADVANCE DIRECTIVES

Physician Orders for Life-Sustaining Treatment (POLST) from and Five Wishes are acceptable if appropriately completed and signed by the necessary parties.

☐ Advance Directives Offered and Discussed Date: __________________________
☐ Decline Advance Directives Date: __________________________