RECEIPT OF NOTICE OF PRIVACY PRACTICES
"ACKNOWLEDGMENT STATEMENT"

My signature on this form acknowledges that I have received a copy of Empath Health's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Empath Health and of my rights with respect to my health information.

I have been provided with an opportunity to discuss concerns I may have regarding the privacy of my health information.

__________________________ __________________________
Patient/Client Signature Date

__________________________ __________________________
Signature of Patient/Client Representative Date
(If patient/client is unable to sign)

THE FOLLOWING SECTION MUST BE COMPLETED IF FORM IS NOT SIGNED BY PATIENT or REPRESENTATIVE

1. Was patient/client or representative provided a copy of Empath Health's Notice of Privacy Practices?
   ☐ Yes ☐ No (If "No," describe emergency that prevented providing a copy)

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2. If Notice was presented but this form was not signed, briefly describe efforts made to obtain signature and note why patient/client or representative were not able or willing to sign this acknowledgment statement:

   ____

   ____

____
Staff Name

________________________________ ______________________
Staff Signature Date

Patients Name: __________________________
Medical Record #: __________________________
Team/Program: __________________________