Carlisle Medical Group, LLC

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: ______________________________

Medical Record Number: N/A

Social Security Number: N/A

Date of Admission: N/A

Notice Version (Date): 9/23/2013

Acknowledgement of receipt of Privacy Practices Notice

I, ______________________________, acknowledge that I have received a Privacy Practices Notice from: CARLISLE FAMILY CARE

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: ______________________ Date: ______________

☐ Notice has previously been distributed by another location in our OHCA (except for physicians):

List location that distributed the Joint Notice: ______________________

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: ______________________________

Relationship to Individual: ______________________________

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form: ______________________

____

____

Describe the reason why the individual would not sign this form: ______________________

____

____

SIGNATURE: (Hospital Representative)

I attest that the above information is correct.

Signature: ______________________ Date: ______________________

Print name: ______________________ Title: ______________________

Include this acknowledgement form in the individual's records.