SAMPLE

Provider's Name:
Address:

Patient's Name:
Medical Record Identifier:
DOB: Gender:
Date of Service:

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

ACUSE DE RECIBO DEL AVIS DE PRACTICAS DE PRIVACIDAD

Al firmar este formularia, usted reconoce que ha recibido el Aviso de Prácticas de Privacidad del _____. El aviso I informa cómo podemos utilizer y divulger su information médica protegida. También hay copias del aviso actual disponibles en:

_____

_____ _____
Firma del paciente/ la persona legalmente Fecha

_____ _____
Nomber (Letra de Molde y Legible) Parentesco con el Paciente

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: _____