

Southwest Florida Medical Center for Age Management, Wellness and Rejuvenation
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: _____ Social Security Number _____
Date of Admission _____ Notice Version (Date): _____

Acknowledgement of receipt n Practices Notice

I, _____, acknowledge that I have received a Privacy Practices Notice from:

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.