Trinity Family Medicine

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

The Patient Reserves the Right to Refuse to Sign this Acknowledgement

I, _____, have received a copy of this office's Privacy Notice.
(**Patient's Name)**

If you accept the terms of the Privacy Notice, please sign below. If the above patient is a minor child or an adult under legal guardianship, the parent/ legal guardian signature is required.

_____/_____

Please Print Name of Person Signing Below **Indicate Self or Relationship to Patient**

_____/_____

Signature **Date**

<u>I authorize the following family members/ friends to receive Protected Health Information on my (the patient's) behalf:</u>**

_____/_____

Name **Relationship**

_____/_____

Name **Relationship**

_____/_____

Name **Relationship**

Additional Persons Authorized to receive Protected Information can be listed on the back of this page.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Notice, but it could not be obtained for the following reason:

[ ] Individual refused to sign.
[ ] Communications barrier prohibited obtaining
[ ] An emergency situation prevented us from obtaining acknowledgement.
[ ] Other (pleasspecify):_____
_____