



D ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospitals and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

Patient Name

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

____/____/____
Date

Description of Personal Representative's Authority

I was not able to obtain the patient's acknowledgement of receipt of the NOPP upon registration because:

- The patient refused to sign despite good faith efforts.
- The patient was unaccompanied and not alert or oriented.
- The patient was unaccompanied and needed emergency care.

Other, (explain) _____

Employee Signature _____ Employee Title _____

Print Name _____ Date ____/____/____

- Acknowledge subsequently obtained, (see above).

MR-205 (Rev 5/04)