Piedmont HEALTHCARE

# ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

*Patient Label*

## ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

❑ I hereby acknowledge that I have received a copy of the Piedmont Providers' "Notice of Privacy Practices."

Print Name of Patient

Signature of Patient or Patient's Authorized Representative | Date | Time

As the Patient's Authorized Representative, my relationship with the Patient is:

The Patient is unable to sign because:

***––––––– OR –––––––***

## CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGMENT

❑ I hereby certify that, as an employee or agent of the Piedmont Providers, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the Piedmont Providers' "Notice of Privacy Practices" in accordance with the policy titled "Provision of the Notice of Privacy Practices."

Print Name of Employee/Agent and Department

Signature of Employee/Agent | Date | Time

Reason(s) For Not Obtaining Acknowledgment: