Joint Notice of Privacy Practices for Health Information (NPP)
Acknowledgement Form

The law requires that this facility give to a patient a copy of its Notice of Privacy Practices for Health Information. This notice describes how medical information about you may be disclosed and how you can get access to this information. We will give you a copy at the time of first treatment and, if we change our notice, thereafter at the next treatment visit. By signing below, you acknowledge receipt of such as the patient, the patient's personal representative, the patient's authorized agent, or an individual involved in the patient's medical care.

Patient Name: _____ Medical Record # _____

Acknowledgment Signature: _____ Date: _____

If signed by anyone other than the patient, please indicate relationship:

Print Name: _____ Relationship: _____

FOR OFFICIAL USE:

I provided a copy of the NPP to the patient/patients representative but was unable to obtain his/her written acknowledgement of receipt of such for the following reasons:

_____

_____

I have attempted to provide to the patient/patients representative a copy of the NPP, but was unable to do so for the following reasons:

_____

_____

Signature of Hospital Representative: _____ Date: _____

Print Name: _____ Department: _____

Aviso conjunto de prácticas de privacidad
de la información médica (NPP, por sus siglas en inglés)
Formulario de acuse de recibo

La ley exige que este establecimiento médico proporcione al paciente una copia de su aviso de prácticas de privacidad de la información médica. Este aviso describe cómo puede ser divulgada su información médica y cómo usted puede obtener acceso a esta información. Le daremos una copia en el momento del primer tratamiento y, si cambiamos nuestro aviso, cuando realice su siguiente visita médica. Al firmar a continuación, usted reconoce haber recibido el presente documento, ya sea como paciente, como representante personal del paciente, como agente autorizado por el paciente, o como una persona que participa en la atención médica del paciente.

Nombre del paciente: _____ N.º de registro médico: _____

Firma de acuse de recibo: _____ Fecha: _____

Si firma en nombre del paciente, indique su grado de parentesco:

Nombre en letra de imprenta: _____ Parentesco: _____

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