Notice of Privacy Practices

Acknowledgement of Receipt

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that I was provided with a copy of the Baylor University Notice of Privacy Practices for Health Services and Clinics.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Print) Patient Signature

**If completed by a patient’s personal representative (e.g., parent or legal guardian), please print and sign your name in the space below.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Representative (Print) Personal Representative Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship

**For Baylor University use only**

Complete this section if this form is not signed and dated by the patient or patient’s personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices but was unable to for the following reason:

□ Patient refused to sign

□ Patient unable to sign

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Name Date

This form should be placed in the patient’s record.

11.21.2023