CHAUTAUQUA COUNTY ACKNOWLEDGMENT

OF RECEIPT OF PRIVACY NOTICE

ONE OF THE FOLLOWING SECTIONS MUST BE COMPLETED

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1. To be completed by the Patient or the Patient's Legal Representative:

I hereby acknowledge that I have received a copy of the County's Privacy Notice.

_____	_____
Name of Patient	Signature of Patient
_____	_____
Signature of Legal Representative (if signed by Legal Representative)	Authority of Legal Representative (e.g., Health Care Proxy, Guardian, Parent)

Date Signed ____/____/_____

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2. To be completed by the Health Care Provider: (<u>Check one of the following boxes if the patient has not signed</u>)

☐ **<u>Patient Refused to Sign</u>**: I or a representative of the Practice exercised a good faith effort to obtain the signature on the above acknowledgment from the patient named below. Our good faith efforts to obtain such signature included requesting that the patient sign this acknowledgement at the time we provided him/her with a copy of the Practice's Privacy Notice. Despite our good faith efforts, the patient failed or refused to sign the above acknowledgement.

☐ **Emergency**: Treatment was delivered during an emergency and, therefore, the Practice was not obligated to obtain the patient's signature on the above acknowledgment. If the patient did not previously receive a copy of the Practice's Privacy Notice, the Practice will mail a copy to the patient after emergency treatment was delivered.

_____ _____

Name of Practice Representative Signature of Practice Representative

_____ _____

Point of Patient Registration Name of Patient
(Name of Facility)

Date Signed ____/____/_____

This document shall be retained six years from the date of its creation
or six years from the date it is last in effect, whichever is later (§164.530(j)(2)).

Effective Date: September 23, 2013	Refer to : 45 CFR 164.520
Authorized by:	Version 2013-1