

# Blue River Family Medicine

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

[May be placed on the consent to treatment form]

I acknowledge that I have received a copy of Blue River Family Medicine's (a department of Manhattan Surgical Hospital) Notice of Privacy Practices with the effective date of September 9, 2013

\_\_\_\_\_  
Signature of Patient/Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient's Name

### For Manhattan Surgical Hospital and Blue River Family Medicine Use Only

The above named Patient/Personal Representative was provided with a copy of Blue River Family Medicine's (a department of Manhattan Surgical Hospital) Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgment of his/her receipt of the Notice, but such acknowledgment could not be obtained because:

\_\_\_ Patient/Personal Representative refused to sign.

\_\_\_ Patient/Personal Representative was unable to sign.

\_\_\_ The Patient had a medical emergency and an attempt to obtain the acknowledgment will be made at the next available opportunity.

\_\_\_ Other reason (please specify): \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Workforce Member Completing Form:

\_\_\_\_\_  
Date

**Original to be maintained in Patient's medical record**