**ACKNOWLEDGMENT OF RECEIPT OF**

**NOTICE OF PRIVACY PRACTICES**

|  |  |  |
| --- | --- | --- |
| *Patient Name* | *Date of Birth* | *MRN* |
| *Address* |

Part I. By signing below, I am acknowledging that:

* I am a patient of the Health & Wellness Department of the Pueblo of San Felipe, or
* I am the Authorized Representative of the patient whose name appears on this form
* That I have received a copy of the Notice of Privacy Practices of the Health & Wellness Department of the Pueblo of San Felipe. The Notice of Privacy Practices describes my rights as a patient regarding my legal health record and the responsibilities of the providers and staff of the Health & Wellness Department in ensuring that they maintain the privacy, confidentiality, and security of my legal health record. The Notice of Privacy Practices also informed me of how my legal health record may be used and disclosed without my authorization.
* I understand that I may contact the Privacy Officer named if I have questions about the content of the Notice or if I believe that my privacy rights have been violated.

|  |  |
| --- | --- |
| SIGNATURE OF PATIENT/AUTHORIZED REPRESENTATIVE *(If Authorized Representative, state* *relationship)* | DATE |
| NAME AND SIGNATURE OF WITNESS *(If signature of the patient is a thumbprint or mark)* | DATE |

**TO BE COMPLETED BY HIIM/HEALTH & WELLNESS STAFF**

Part II. Complete if signature was requested but NOT obtained – Staff member was unable to obtain an acknowledgment from the patient/patient’s authorized representative for the following reason(s):

 \_\_\_\_\_ Patient/Authorized Representative refused to sign

 \_\_\_\_\_ Other: *(Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Part III. Complete if patient/authorized representative is unable to sign the Notice form on the first date of service delivery:

 \_\_\_\_\_ Notice of Privacy Practices form mailed/sent to patient/authorized representative on *(Date)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Part IV. Signature of the Health & Wellness Staff who process the Notice

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NAME and SIGNATURE DATE