Resolution Health Collaborative

Acknowledgment of Receipt of Notice of Privacy Practices

First	Middle	Last	Patient ID#

I hereby acknowledge that I have received a copy of Resolution Health Collaborative's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgment if I so choose.

Signature of Patient or Legal Representative _____ Date _____

Printed Name of Patient's Representative (if applicable) _____ Date _____

Relationship to Patient
If applicable

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of attorney

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices on the following date____ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgment at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgment (Explain)

_____

_____

_____

_____

☐ Other (Specify)

_____

_____

_____

_____