MIDWEST HEART SPECIALISTS

NOTICE ACKNOWLEDGEMENT
(Provider)

Purpose: This form is used to document an individual's acknowledgement of receipt of our Privacy Practices Notice or our good faith, but unsuccessful effort to obtain that acknowledgement. We are not obligated to attempt to obtain this acknowledgement in an emergency treatment situation.

SECTION A: Individual receiving Privacy Practices Notice.

Name: ____

Address: ____

Telephone: ______________________ E-mail: ______________________

Date of Birth: ______________________

TO THE INDIVIDUAL: Please complete the following acknowledgement.

I acknowledge that I received the Privacy Practices Notice of **Midwest Heart Specialists**

Signature: ______________________ Date: ______________________

If this acknowledgement is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: ______________________________

Relationship to Individual: ______________________________

SECTION B: Good faith effort to obtain acknowledgement (complete only if individual refuses written acknowledge of receipt of Privacy Practices Notice on this form or otherwise).

☐ Individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice. Describe your good faith effort to obtain the individual's signed acknowledgement and the reason you were unsuccessful:

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☐ Individual received the joint Privacy Practices Notice applicable to our organization from another participant in our organized health care arrangement. We are therefore not required to deliver a Notice or obtain an acknowledgement. Attach a copy of the acknowledgement, or the documentation of the unsuccessful good faith effort to obtain acknowledgement, from the participant who furnished the joint Notice.

☐ Individual received our Privacy Practices Notice in connection to an emergency treatment situation. We are not required to obtain an acknowledgement.

SIGNATURE.

I attest that the above information is correct.

Signature: ______________________ Date: ______________________

Print name: ______________________ Title: ______________________

Include completed form in the individual's records.
Update HIPAA section in demographics section of practice management system