



Notice of Privacy Practices

Acknowledgment of Receipt

(Please complete, print, sign and bring at your visit)

I acknowledge that I was provided with a copy of Brookhaven Heart PLLC's Notice of Privacy Practices. *(We are not obligated to attempt to obtain this acknowledgement in an emergency treatment situation).*

Signature(Required)	Date Signed(Required) (Month/DD/YYYY)
Patient Name:	

• If the patient is 18 years of age or older and incapable of signing, legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship ☐ Legal Guardian ☐ Health care agent • If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form unless exception exists under federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian	
Signature(Required)	Date Signed(Required) (Month/DD/YYYY)
Print Name of Person Signing:	

For Brookhaven Heart PLLC's use only Complete this section if this form is not signed and dated by the patient or patient's personal representative. I have made a good faith effort to obtain a written acknowledgement of receipt of Brookhaven Heart PLLC's Notice of Privacy Practices but was unable to for the following reason: ☐ Patient refused to sign ☐ Patient unable to sign ☐ Other _____ _____ Employee Name Date
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Include completed form in patients' medical records