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)*
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)*
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

Include completed form in patients' medical records

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