Effective Date: 01/2016 Updates: 4/27/2021js

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Resident Name: _____Medical Record No._____

Address: _____

Facility Name: _____

I, _____, have been given a copy of Iron County Medical
Resident's/Legal Representative's Name

Care Facility's *Notice of Privacy Practices ("Notice*"), which describes how my health information is used and shared. I understand that Iron County Medical Care Facility has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Facility Privacy Officer, or by visiting Iron County Medical Care Facility's web site at ironcountymcf.com.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Resident or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement:*

_____

_____

Completed by:

_____ _____
Signature of Facility Representative Date

_____
Printed Name of Facility Representative

***File original in resident's Business Office Record**