DOB: EMRN:

ACCT #:

LOCATION:

* - - *

Notice of Privacy Practices

Acknowledgement of Receipt

By signing below, I acknowledge that I have been provided a copy of the AU Medical Center, AU Medical Associates, and Augusta University joint Notice of Privacy Practices, which informs me how my medical information may be used and disclosed and how I may obtain access to this information.

______________________________________ ______________

Signature of Patient or Personal Representative. Date

____

Print Name of Patient or Personal Representative

____

Personal Representative's Authority / Verification Attached (check box _______)

****

Internal use only - when signed acknowledgement of receipt is not provided or refused

In accordance with this organization's policies and procedures, AU personnel have made a "good faith effort" to obtain from the patient his/her signed Acknowledgement of Receipt of joint Notice of Privacy Practices. Examples of "a good
faith effort" may be: (1) an acknowledgment list that the patient/personal representative signs; (2) a coversheet with the patient/personal representative's initials; or (3) in the case of pharmacy, an initialed acknowledgement of receipt in the same pharmacy log book used to sign for the prescription itself.

Please provide a brief description of your "good faith effort":

____

____

____

____

AU Staff Name and Title: _________________________________

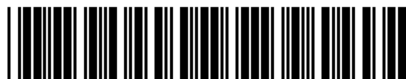
Patient Name: ____

Patient number: ____

Date: _______________________________ Time: __________________________

HI 25 / 15273 8/13

Rev. 08/22/2013; FOD FORM # MCG362



PRIVACKN