ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

________________________________ (insert individual name) acknowledge that I received a copy of Mercy Medical Center Notice of Privacy Practices dated 11/2014 (Insert date of Notice of Privacy Practices).

______________________________
(Individual’s signature or initials)

______________________________
(Personal representative of individual, if individual is unable to sign)

______________________________
(Date)

______________________________    _________________
(Witness signature    Date)

Individual (or personal representative of the individual) did not sign the acknowledgement for the following reason:

(check (√) one of the reasons below)

☐ Individual refused
☐ Individual refused, stating that he/she has already signed an acknowledgement
☐ Individual unable to sign because of medical condition
☐ There was not a personal representative of the individual available to sign
☐ Other (explain) ________________________________

____________________________________________________

Witness    Date