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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I hereby acknowledge that a copy of University Orthopaedics, P.C. Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about University Orthopaedics, P.C. privacy practices or my rights regarding my personal health information, I may contact the University Orthopaedics, P.C. privacy officer for further information.

Name of Patient (please print) _____

Name of Patient's Personal Representative _____

Signature _____ Date _____

If signed by personal representative, note here the representative's authority to act on behalf of patient:

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGMENT:

Patient Name: _____ ID Number: _____

I certify that on _____ (date) I made a good faith effort to obtain the patient's signed acknowledgment of receipt of Notice of Privacy Practices, but was unable to do so because:

Name of staff (please print) _____

Signature of staff _____ Date _____

NOTE: THIS DOCUMENT SHOULD BE MAINTAINED PERMANENTLY IN THE PATIENT'S MEDICAL RECORD OR OTHER FILE ON PROVIDER'S PREMISES