VINTON and DAVENPORT

NOTICE OF PRIVACY PRACTICES

Record of Acknowledgement

Name of Resident:________________________________ Date:__________

Acknowledgement

June 4, 2014

I certify that I have received a copy of this facility's *Privacy Notice* and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the facility is committed to protecting my health information.

Date:____________ My Signature:________________________________

My Printed Name: ____________________________

Date:____________ Signature of Witness:__________________________

I certify that I am the authorized representative of_________________________, and that I have received the *Privacy Notice* on behalf of this individual and that the facility provided me with an opportunity to review this document and ask questions to assist me in understanding his/her privacy rights. I am satisfied with the explanations provided to me and I am confident that the facility is committed to protecting health information.

Date_____________ Signature of Representative:___________________

Printed Name: ______________________________

Relationship to Individual: ____________________

Date:____________ Signature of Witness__________________________

This form was not signed because (Check One):

_____Emergency (resident unable to sign and no legal representative available)

_____Resident (or legal representative) refused to sign after being requested to do so

_____Other____

A copy of this acknowledgement must be offered and/or provided to the person to whom the Privacy Notice was provided and a copy must be filed in the medical record.