HENRY FORD HEALTH℠

Acknowledgement of Receipt of Privacy Practices

Place patient label here or fill out information below:

Patient Name: _____

Date of Birth: _____

MRN: _____

I agree that I did receive a copy of the Henry Ford Health Notice of Privacy Practices.

_____ _____ _____

Signature of initials of patient or authorized representative* Date Time

_____

Printed name of authorized representative (if applicable)

*Authorized representatives include:

- Parent of a Minor
- Legal Guardian (copy of documentation may be needed)
- Personal Representative (copy of documentation may be needed)
- Person under a durable medical Power of Attorney (POA) (copy of documentation may be needed)

For Henry Ford Health Use Only

Document good faith effort:

- ☐ Offered Notice & Acknowledgement to Patient or Representative
- ☐ Offered to secure an interpreter to present Notice and Acknowledgement to Patient or Representative
- ☐ Other _____

If good faith effort is not successful and acknowledgement is not obtained, document your efforts and reason why:

- ☐ Patient unable to sign/notice given to caregiver
- ☐ Incapacitated patient/no patient representative present/emergency treatment
- ☐ Patient/representative declined to receive notice
- ☐ Patient/representative declined interpreter
- ☐ Other _____

_____ _____

Workforce member signature Date of attempt to obtain acknowledgement