NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

Name: _____

Clinic Location: _____

I have received a copy of the CAN Community Health Privacy Practices

E-Signature: _____ **Date:** _____
Individual or Representative with legal authority to make health care decisions

If signed by a Representative:

Print Name: _____ Role: _____
(Parent, guardian, etc.)

Witness: _____ Date: _____

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the representative. ***If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain i t.***

Notice of Privacy Practices given to the individual on: _____
Date

☐ Face to face meeting
☐ Mailing
☐ Email
☐ Other _____

Reason Individual or Representative did not sign this form:

___ Individual or Representative chose not to sign
___ Individual or Representative did not respond after more than **one** attempt
___ Email receipt verification
___ Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.

Face to face presentation(s) _____
Telephone contact(s) _____
Mailing(s) _____
Email _____
Other _____

Staff E-Signature: _____ **Date**: _____

Print Name: _____ **Date:** _____

Name _____
ID# _____
Date of Birth _____/_____/_____