Date: ______________________
MRN (or Date of Birth): ______________
Name: ______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receiving a copy of the Henry Ford Health System Notice of Privacy Practices.

____
Signature or initials of patient or authorized representative*

____
Printed name of authorized representative (if applicable)

*Authorized representatives include:

- Parent of Minor
- Legal Guardian
- Personal Representative
- Person under a durable medical Power of Attorney (POA)

For Legal Guardian, Personal Representative or person with authority under a durable medical power of attorney, a copy of appropriate documentation may be necessary.

FOR HFHS USE ONLY

For Workforce Member 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 unsuccessful and Acknowledgement is not obtained, document your efforts and reason why the acknowledgement was not obtained:

Reason Acknowledgement was not obtained:

- ☐ 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: ______________________________

Upon completion scan or file in the patient's record. If form needs to be emailed or faxed, please do so at IPSO@hfhs.org or (313) 874-9449. If form needs to be mailed, please send it to Information Privacy & Security Office, 1 Ford Place, Suite 2A, Detroit, MI 48202.