_____

Last Name **First Name** **MI**

Date of Birth: ____/_____/_____

ACKNOWLEDGEMENT

RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" Macon County Public Health;
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

_____ _____

Signature of patient or parent/legal guardian/legally responsible person Date

_____

Description of relationship to patient

All telephone numbers provided may be subject to receiving telephone calls from an automated dialer using a pre-recorded, artificial voice message or live operator call. I give my express consent to receive such phone calls, including any calls made to the cellular telephone number that I have provided.

_____ _____

Signature of patient or parent/legal guardian/legally responsible person Date

I authorize the release of any medical or other information necessary to process this claim for payment. I request payment of benefits to Macon County Public Health and assigned entities or suppliers of services.

_____ _____

Signature of patient or parent/legal guardian/legally responsible person Date

TO BE COMPLETED BY STAFF

Complete all applicable parts—Please refer to instructions

Part 1. Complete if signature requested but not obtained:

Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

☐ Patient/personal representative refused to sign form

☐ Other _____

Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:

☐ Form mailed/sent to patient/personal representative on _____.

Date

Part 3. Complete if either Part 1 or Part 2 completed:

_____ _____

Signature of staff member Date