



Receipt of Notice of Privacy Practices

Patient Name _____

Medical Record # _____

Date of Admission _____

My signature on this form acknowledges that I have received a copy of The Sun Home Health Inc. Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by The Sun Home Health, Inc. and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Patients' Signature

Date

Signature of Patient's Representative
if patient is unable to sign

Date

TO BE COMPLETED BY ADMITTING CLINICIAN IF FORM IS NOT SIGNED

Was provided with a copy of the agency's Notice of Privacy Practices? Yes No

Briefly describe efforts made to obtain the patient's acknowledgment of receipt of the Notice and explain why the patient was not able or willing to sign this form:

Signature of Admitting Clinician

Date