821 N Cobb Street
Milledgeville, Ga. 31061

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name:____

Patient Acknowledgement: I, the undersigned, acknowledge receipt of Navicent Health Baldwin's Notice of Privacy Practices and/or a Summary of the Notice of Privacy Practices. I further acknowledge I have been provided with an opportunity to ask questions regarding the Notice and its contents, and understand that my medical information will be included in a health information exchange.

____ __________
Signature or Initials of Patient or Patient's Authorized Representative **Date/Time**

____
Printed name of patient's authorized representative

Basis of Authority to Sign for Patient: ____
____

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The patient was provided with a copy of the Notice of Privacy Practices and/or the Summary of Notice of Privacy Practices and the good faith attempt to obtain the patient's signature acknowledging receipt of the Notice was unsuccessful due to the following:

☐ Patient incapacitated and unable to sign acknowledgment

☐ Patient or patient's authorized representative refused/declined to sign acknowledgment

☐ Other: ____

____ ___________ __________
Signature of Hospital Representative **Date** **Time**

Form: HIPAA 04/2003; 2/2013, 06/01/2014, 10/1/2017

Patient