Oakwood

Name:

DOB:

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Oakwood Healthcare Notice of Privacy Practices. I understand this Notice provides me with information on my privacy rights and how my health information may be used and disclosed.

_____ _____

Signature of Patient or Representative Date

_____

Relationship to Patient

_____

Printed or Typed Name

_____ _____

Witness or Signature of Oakwood Employee Date

If the patient does not sign this acknowledgement, please identify what effort was made to obtain an acknowledgement:

- ☐ Patient given a copy of the Notice but refused to sign form.
- ☐ Patient unable to sign related to:
  - ☐ Emergency treatment situation
  - ☐ Unconscious
  - ☐ Mentally Incompetent
  - ☐ Language Barrier
  - ☐ Other (explain): _____

_____

_____

_____ _____

Signature of Oakwood Employee Date