PROVIDENCE
Health & Services

OREGON REGION

ACKNOWLEDGEMENT OF RECEIPT OF THE *JOINT NOTICE OF PRIVACY PRACTICES*

PATIENT IMPRINT

Purpose: This form is used to document the Providence Health & Services Oregon Region Joint Notice of Privacy Practices was given to the patient or their personal representative, as required by federal law.

By signing this form, you acknowledge receipt of the Providence Health & Services Oregon Region Joint Notice of Privacy Practices. Our notice provides information about how we may use and disclose your protected health information. We encourage you to review the notice carefully.

I acknowledge receipt of Providence Health & Services Oregon Region Joint Notice of Privacy Practices

Signature: _____ Date: _____
(Patient or personal representative)

If you are signing as a personal representative, please complete the following.

Print personal representative's name: _____

Relationship to patient: _____

For Official Providence Use Only

Inability to Obtain Acknowledgement

To be completed only if a signature is not obtained. Describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____

_____

Notice already given: ☐ Location: _____ Date: _____

Signature of PH&S representative: _____ Date: _____