Main Line HealthCare
Physician Network

Acknowledgement of Receipt of Notice of Privacy Practices

PATIENT NAME:_____ **MRN:**_____
(Print full name)

DATE OF BIRTH (required):_____

By signing below, I acknowledge receipt of the *Notice of Privacy Practices* of Main Line HealthCare and the Main Line Health System ("MLHS").

Signature: _____ Date:_____

Inability to Obtain Acknowledgement (To be completed only if no signature is obtained).

No acknowledgement of receipt of Privacy Practices was obtained from the patient because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please specify):

Signature of MLHC representative: _____Date:_____