FORM – ZNPP

Acknowledgement of receipt of Notice of Privacy Practices

By signing below, I acknowledge receipt of the Notice of Privacy Practices of Main Line Health (MLH). In addition, by signing below, I authorize MLH to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

__________________________________________
Signature of patient                        or
__________________________________________
Signature or personal representative

__________________________________________
Patient name – PRINT                         
__________________________________________
Personal representative’s name – PRINT

__________________________________________
Date and time                                
__________________________________________
Date and time

__________________________________________
Relationship to patient

____________________________________________________________________________

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 MLH representative                 
__________________________________________
Date and time

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