Notice of Privacy Practices
Acknowledgment of Receipt

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I acknowledge that I have received or have been given the opportunity to receive a copy of MedLink Georgia's Notice of Privacy Practices. I also understand that MedLink Georgia has the right to change its Notice of Privacy Practices and that I may contact any office to obtain a current copy of the Notices of Privacy Practices.

I further acknowledge that I have had a chance to ask questions about how my information will be used

_____ _____
Patient's Printed name Date

Or

_____
Patient's Signature

_____
Patient's Representative (Printed) Signature

This document will be filed in the patient's electronic medical record as required by HIPAA regulations. The Notice of Privacy practices will be provided upon request in alternative formats for individuals with disabilities or in a language other than English for people with limited English proficiency.

FOR OFFICE USE ONLY:

We have made the following attempt to obtain the patient's/representative's signature acknowledging receipt of the Notice of Privacy Practices:

- ☐ Patient/representative refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Communications barriers prohibited us from obtaining acknowledgement
- ☐ Other _____

_____
Staff Member's Name (Printed) Signature Date