



ACKNOWLEDGMENT OF RECEIPT OF JOINT NOTICE OF PRIVACY PRACTICES

I acknowledge that I received a copy of Barton Health's Joint Notice of Privacy Practices.

Patient, Guardian or Responsible Party Signature: _____

Printed Name: _____ Relationship: _____

Date (MM/DD/YYYY): _____ Time: _____

OFFICE USE ONLY

- Signed acknowledgment received

Staff Printed Name: _____

- Acknowledgement refusal

Staff Printed Name: _____

Describe good faith efforts to obtain acknowledgment:

Describe reasons why acknowledgment was not obtained:

Staff Signature: _____

Staff Printed Name: _____

Name: _____

DOB: _____ MRN: _____



ACUSE DE RECIBO DE NOTIFICACIÓN CONJUNTA DE PRÁCTICAS DE CONFIDENCIALIDAD

Reconozco que he recibido una copia de la Notificación Conjunta de Prácticas de Confidencialidad de Barton Health.

Firma del paciente, tutor o parte responsable: _____

Nombre en letra de molde: _____ Relación: _____

Fecha (MM/DD/AAAA): _____ Hora: _____

OFFICE USE ONLY

- Signed acknowledgment received

Staff Printed Name: _____

- Acknowledgement refusal

Staff Printed Name: _____

Describe good faith efforts to obtain acknowledgment:

Describe reasons why acknowledgment was not obtained:

Staff Signature: _____

Staff Printed Name: _____

Name: _____

DOB: _____ MRN: _____