



Patient Label

**ACKNOWLEDGMENT OF RECEIPT OF
“NOTICE OF PRIVACY PRACTICES”**

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I hereby acknowledge that I have received a copy of the Piedmont Providers’ “Notice of Privacy Practices.”

Print Name of Patient

Signature of Patient or Patient’s Authorized Representative Date Time

As the Patient’s Authorized Representative, my relationship with the patient is: _____

The Patient is unable to sign because: _____

_____ **OR** _____

CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGMENT

I hereby certify that, as an employee or agent of the Piedmont Providers, I have made a good faith effort to obtain from the patient or the patient’s authorized representative a written acknowledgment of the Piedmont Providers’ “Notice of Privacy Practices” in accordance with the policy titled “Provision of the Notice of Privacy Practices.”

Print Name of Employee/Agent and Department

Signature of Employee/Agent Date Time

Reason(s) For Not Obtaining Acknowledgment:

