Chautauqua County Department of Health and Human Services
7 North Erie Street, Mayville, NY 14757

Acknowledgement of Receipt of Notice of Privacy Practices, Patient Bill of Rights and Health Care Proxy

This form is being provided to acknowledge your receipt of our *Notice of Privacy Practices, Patient Bill of Rights, and Health Care Proxy.*

What is the Notice of Privacy Practices?
The Notice of Privacy Practices explains how our patient health information may be used or disclosed by us. In addition, it explains your rights with regard to your patient health information, as well as our legal responsibilities.

What is the Bill of Rights?
The Patient Bill of Rights is a statement of the rights to which patients are entitled as recipients of medical care.

What is a Health Care Proxy? (This only applies if you are 18 years of age or older)
A Health Care Proxy allows you to appoint someone you trust – for example, a family member or close friend, to make health care decisions for you if you lose the ability to make decisions yourself. All competent adults, 18 years of age or older, can appoint a health care agent.

Acknowledgement of Receipt:
By signing below, you are acknowledging that the Notice of Privacy Practices, Patient Bill of Rights and Health Care Proxy have been provided to you.

I, _____
(Printed Name of patient or others subject to this consent; e.g. minors)

Residing at (address): _____

I have received the Notice of Privacy Practices and Patient Bill of Rights from Chautauqua County Department of Health and Human Services.

_____ _____
Signature Date

[Note: Form to be kept in patient's Health Department record for six (6) years from the date of its creation or the date it was last in effect, whichever is later]

One of the Following Sections MUST be Completed

1. To be completed by the Patient or the Patient's Legal Representative:

I hereby acknowledge that I have received a copy of the County's Privacy Notice.

_____ _____
Name of Patient Signature of Patient

_____ _____
Signature of Legal Representative (if signed by Legal Representative)

Authority of Legal Representative (e.g., Health Care Proxy, Guardian, Parent)

Date Signed ____/____/_____

2. To be completed by the Health Care Provider: (Check one of the following boxes if the patient has not signed)

❑ **Patient Refused to Sign**: I or a representative of the Practice exercised a good faith effort to obtain the signature on the above acknowledgment from the patient named below. Our good faith efforts to obtain such signature included requesting that the patient sign this acknowledgement at the time we provided him/her with a copy of the Practice's Privacy Notice. Despite our good faith efforts, the patient failed or refused to sign the above acknowledgement.

❑ **Emergency**: Treatment was delivered during an emergency and, therefore, the Practice was not obligated to obtain the patient's signature on the above acknowledgment. If the patient did not previously receive a copy of the Practice's Privacy Notice, the Practice will mail a copy to the patient after emergency treatment was delivered.

Name of Practice Representative Signature of Practice Representative

_____ _____
Point of Patient Registration Name of Patient(Name of Facility)

Date Signed ____/____/_____

This document shall be retained six years from the date of its creationor six years from the date it is last in effect, whichever is later (§164.530(j)(2)).
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