Print Form

WOOSTER COMMUNITY HOSPITAL

Acknowledgment by Patient or Patient's Representation of Receipt of Notice of Privacy Practices

I acknowledge receiving a copy of the Notice of Privacy Practices given to me by Wooster Community Hospital (or one of its related services), at the first date of service (following April 14, 2003)

I understand this Notice explains what Wooster Community Hospital does to protect the use or disclosure of my health care information. I will share this Notice with other adult members of my household.

I understand I should keep it and refer to it if I have questions. I also understand I should call the Hospital's Privacy Officer at 330-263-8615 if I have a question or concern about my privacy rights. I also may contact the Hospital's website at www.woosterhospital.org.

_____
Printed name of patient

_____
(If applicable) Printed name of patients representative and relationship to patient

_____
Signature by patient or patients representative

_____
Date

HOSPITAL STAFF USE ONLY IF ACKNOWLEDGMENT NOT SIGNED

The following attempt(s) were made to obtain a written Acknowledment of Receipt

- ☐ NPP given to patient, who refused to sign.
- ☐ NPP left with family member or friend.
- ☐ Patient unable to sign/emergency.
- ☐ NPP mailed to patients home address or alternate address.
- ☐ NPP was faxed or emailed to patient, at patient' s request.

Other reason(s) why written acknowledgement not obtained:_____

_____
Signature of Person attempting to obtain signed Acknowledgment

_____
Date

COPY MAINTAINED IN FILE

Patient Label

39513 MR047 Rev. 10/09