ArnotHealth
Arnot Medical Services

Date: ____________________

HIPAA Acknowledgement and Consent

The undersigned understands that the Medical Center is required by law to maintain privacy of protected health information and has provided the patient/patient's representative with a notice of its privacy practices regarding health information.

Patient's Name: ________________________________ **Date of Birth:** ____________

Patient Signature: ____

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Patient's Representative (if applicable) **Relationship to Patient**

Please check all that may apply:

- ☐ **Office may leave message on answering machine.**
- ☐ **Office may call cell phone ________________________.**
- ☐ **Office may call patient at work ____________________.**
- ☐ **Office may leave message with spouse and/or significant other.**
- ☐ **Office should only speak with patient.**
- ☐ **Information may be given to other family members. List: ______________________**
  ____

AMS Office Use Only:

An attempt was made to obtain a written acknowledgement of receipt of our Notice Privacy Practices, but the acknowledgment could not be obtained because:

- ☐ The individual refused to sign
- ☐ Communication barriers prevented our obtaining the acknowledgement
- ☐ An emergency situation prevented our obtaining the acknowledgement
- ☐ Other (please specify) ____

AMS Employee: ____ Date: ____________________________

Last updated 8/12/2015