State of Florida
Department of Health

Notice of Privacy Practices Acknowledgment Form

Name: _____ Client ID# _____

Facility/Site/Program: ***Alachua County Health Department/ Main/ Health Department Programs***

I have received a copy of the DOH Notice of Privacy Practices Form DH 150-741, 09/13.

Signature: _____ Date: _____
Individual or Representative with legal authority to make health care decisions

If signed by a Representative:

Print Name: _____ Role: _____
(Parent, guardian, etc.)

Witness: _____ Date: _____

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the representative. ***If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.***

Notice of Privacy Practices given to the individual on _____
date

___ Face to face meeting
___ Mailing
___ Email
___ Other _____

Reason Individual or Representative did not sign this form:
___ Individual or Representative chose not to sign
___ Individual or Representative did not respond after more than **one** attempt
___ Email receipt verification
___ Other _____

Good Faith Efforts: The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.
___ Face to face presentation(s) _____
___ Telephone contact(s) _____
___ Mailing(s) _____
___ Email _____
___ Other _____

Staff Signature: _____ Title:_____

Print Name: _____

Date: _____

This form must be retained for a period of at least six years in the appropriate record.