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

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 meeting __________________ _______________________________________
___ 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.

DOH Notice of Privacy Practices Acknowledgement Form, DH 150-741, 09/13