By signing this document, I acknowledge that I have received a copy of The Primary Care and Specialty Clinics of Liberty Hospital Notice of Privacy Practices and Patient Rights.

Patient Signature: __________________________________ Date ________ Time ________

Patient Representative/Relationship Signature: __________________________________ Date ________ Time ________

Witness: __________________________________ Date ________ Time ________

The Primary Care and Specialty Clinics of Liberty Hospital use only:

If the patient’s signature was not obtained, please describe reason why below:

☐ Patient refused to sign Acknowledgement.

☐ Patient unable to sign Acknowledgement due to emergent condition.

Other: Describe below:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

The Primary Care and Specialty Clinics of Liberty Hospital is required by law to make a good faith effort to obtain a written acknowledgement from the patient receiving treatment regarding receipt of our Notice of Privacy Practices. A patient’s failure or refusal of this acknowledgement should not interfere with delivery of treatment. 45 CFR 164.520

The Primary Care and Specialty Clinics of Liberty Hospital is required to inform each patient of their patient rights in advance of providing or stopping care. 42 CFR 482.13.a (1) Interpretive Guidelines