

**UNIVERSITY OF SOUTH FLORIDA COLLEGES OF MEDICINE AND NURSING
ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Version of Notice of Privacy Practices Provided: 04/14/2003

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

Signature of Patient (or Authorized Personal Representative)

Date

Print Name of Patient (or Authorized Personal Representative)

Authority of Personal Representative
(e.g., parent, legal guardian, health
care surrogate)

**DOCUMENTATION OF GOOD FAITH EFFORTS
TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

The patient presented for his/her service on this date and was provided a copy of the USF Colleges of Medicine and Nursing Notice of Privacy Practices (Notice). A good faith effort was made to obtain a written acknowledgement of receipt of the Notice. However, an acknowledgment of receipt was not obtained because of the following reason(s):

- Patient refused to sign the Acknowledgement of Receipt.
- Patient was unable to sign or initial the Acknowledgement of Receipt.
- There was a medical emergency, and an attempt will be made to obtain an Acknowledgement of Receipt at the next available opportunity.

Signature of employee completing the form

Date

Print name of employee

Affix Patient Label:

File Original in the Medical Record