Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Arkansas Valley Accumed's Notice of Privacy Practices.

____ ____/____/________
Name of Patient (Please Print) Date of Birth

____ ____/____/________
Signature of Patient or Personal Representative Date

____ _________________________
Name of Personal Representative (Please Print) Relationship to Patient

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Documentation of Good Faith Effort to obtain acknowledgment of receipt of Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient)

I hereby certify that on ___/___/_____ (mm/dd/yyyy), I made a good faith effort to obtain the above patient's written acknowledgement of his/her receipt of Arkansas Valley Accumed Notice of Privacy Practices. However, such acknowledgment was not obtained because:

- ❑ Patient refused to sign
- ❑ Patient was unable to sign or initial because:

____

- ❑ The Patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ❑ A copy of the Notice was **MAILED / E-MAILED** (circle one) to most recent address on file.
- ❑ Other Reason:

____

____
Printed name of employee completing form

______________________________________ ____/____/________
Signature of employee completing form Date

**Per HIPAA documentation requirements pharmacy must keep the patient's signature acknowledging receipt of Notice of Privacy Practices for a minimum of six years.*

Request to Access or Release