PATIENT ACKNOWEDGEMENT OF DISCLOSURE INFORMATION

My signature below acknowledges the following:

- I have received a copy and/or I am aware of the PATIENT BILL OF RIGHTS, as required by law, and have had an opportunity to receive assistance in understanding and exercising these rights.
- I have received a copy and/or I am aware of this office's NOTICE OF PRIVACY PRACTICES, including the PRIVATE HEALTH INFORMATION (PHI) designated at the time of my visit.
- I have received information about and/or I am aware of the SPEAK UP PROGRAM.
- I have received information about and/or I am aware of the Infection Control measures utilized by this organization.
- I have received a copy and/or I am aware of the PRACTICE DISCLOSURE (about our practice, including the Grievance Process) and am comfortable with that information. I also understand this practice's position on DO NOT RESUSCITATE (DNR) and LIVING WILLS, and that this practice does not honor these directives.

Patient Name (*print*):

____

Signature of Patient/Representative: _______________________________ Date: _______________

Above signature was not obtained because:

☐ Patient is unable and unaccompanied by a representative. Patient left with all pertinent disclosures

☐ Patient refused to sign.

☐ Patient refused forms.

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