**Taylor Health and Wellness Center**
Missouri State University
901 S. National Avenue, Springfield, MO 65897
Phone: (417) 836-4000 Fax: (417) 836-4133 http://health.missouristate.edu

# NOTICE OF ACKNOWLEDGEMENT
## FOR PROTECTED HEALTH INFORMATION

**Purpose:** This form is used to document an individual's acknowledgement of receipt of our Notice of Privacy Practices.

Section 1: **PATIENT IDENTIFICATION.** Please complete all of this section.

Print Name: (Last)_____(First)_____ (Middle)_____

Address, City, State, & Zip Code: _____

Social Security #: _____ e-mail Address: _____

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I have completed the above and acknowledge receipt of the attached Notice dated April 14, 2003. I understand that the Notice and updates will always be available to me at: http://health.missouristate.edu.

_____ _____

**Signature of Patient** **Date**
(If under 18 years of age - Parent, Legal Guardian, or Legal Representative)

If you are not the person listed above, please describe your relationship to him/her: _____

(Patient, do not complete below.)

## *OFFICIAL USE ONLY*

Section 2: **GOOD FAITH EFFORT.** A good faith effort was made to obtain a written acknowledgment of receipt of the Notice of Privacy Practices. However, a signed acknowledgment was not obtained because:

0 Patient was experiencing a medical emergency. Obtaining a signed acknowledgment shall be attempted at the next visit or will be sent to patient.

0 Patient did not sign for the following reason(s): _____

_____

_____ _____

**Signature of Taylor Staff Completing Section 2** **Date**

**Taylor Staff Initials:** _____

A copy of this form will be filed in the above-named patient's PHI.