NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Protected health information may be used and disclosed to carry out treatment, payment or healthcare operations. Please refer to the Notice of Privacy Practices for complete description of uses and disclosures. I acknowledge that I have received a written Notice of Privacy Practices.

By signing below, I acknowledge that I have received a copy of the BSA Health System Notice of Privacy Practices and that I agree to uses and disclosures described in the Notice of Privacy Practices listed under the section: How We May Use and Disclose Your Health Information.

_____	_____	_____
Patient Name (Print)	Signature	Date

-OR-

_____	_____	_____
Patient Personal Representative (Print)	Signature	Date

BSA Health System Use Only

Date acknowledgement received: _____

Signature of BSA employee: _____

-OR-

Reason acknowledgement was not obtained (declined to sign):

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify)_____