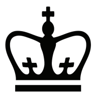 COLUMBIA HEALTH

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:____________________

I acknowledge that I was provided with a copy of the Columbia Health Notice of Privacy Practices.

___________________________	_____________________________	__________
Patient Name Print)	Patient Signature	UNI

If completed by a patient's personal representative, please print and sign your name in the space below

__________________________________	______________________________
Personal Representative (Print)	Personal Representative's Signature
	______________________________
	Relationship

For Columbia Health use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Columbia Health Notice of Privacy Practices but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient unable to sign
- ☐ Other ________________

_________________________	_______________________
Employee Name	Date

This form should be placed in the patient's medical record

Revised March 2014