(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

Acknowledgment of Receipt of Privacy Notice

By signing this form, you are only agreeing that you have received a copy of the
UAMS Notice of Privacy Practices.

____ _______________ _______________
Patient or Legal Representative's Signature Date Time

____
Print Legal Representative's Name (if applicable)

If Legal Representative, authority of Legal Representative _______________________________________
(such as parent of minor, guardian, administrator of estate of deceased, attorney-in-fact appointed with power of attorney, or healthcare proxy)

STAFF USE ONLY

We provided the Notice of Privacy Practices and attempted to obtain written acknowledgment but acknowledgment could not be obtained because:

☐ Patient or Legal Representative declined to sign the Acknowledgment of Receipt

☐ Other (please specify) ____

____

____ _______________ _______________
Signature of Employee Completing Form Date Time

____ ___________________________________
Print Name of Employee Completing Form UAMS Location