If label not available, please fill in below.

NAME: _____

DOB: _____

MRN: _____

Form A

WELLSPAN®
Medical Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided a copy of WellSpan Health's Notice of Privacy Practices.

_____ _____

DATE SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____ _____

TIME PRINTED NAME

Please see www.wellspan.org/disclaimer-policies/hipaa-privacy for WellSpan Health Notice of Privacy Pratices.

If label not available, please fill in below.

NAME: _____

DOB: _____

MRN: _____

Form B

WellSpan®
Medical Group

DO NOT COMPLETE IF FORM "A" HAS BEEN SIGNED

GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGMENT OF RECEIPT OF NOTICE

For use only when efforts to obtain acknowledgement of receipt of notice are unsuccessful

Personal representative information **(if applicable):**

_____ _____

NAME OF PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

I provided the above named patient (or patient's representative) with the WellSpan Notice of Privacy Practices.

Describe efforts to provide Notice and obtain signature:

☐ Offered copy and individual refused to accept delivery

☐ Patient/personal representative was asked to sign form and refused

☐ Patient claims they have already received the WellSpan Notice of Privacy Practices

☐ Other _____

_____

_____

_____

_____ _____

SIGNATURE DATE

_____ _____

PRINTED NAME TIME

Form #8730 Rev. (09/02/15)