

**Mississippi State Department of Health**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
FOR PROTECTED HEALTH INFORMATION**

By signing below, I acknowledge that I have received a Notice of Privacy Practices for Protected Health Information from the Mississippi State Department of Health.

Name of Patient (Please Print) \_\_\_\_\_

Name of Personal Representative (if signing for patient) (Please Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- Patient
- Parent or Guardian of Minor Patients
- Other (*If not signed by the Parent or Guardian of a minor patient, please indicate your relationship to the Patient and provide any required documentation confirming your authority to act for the Patient*)

\_\_\_\_\_

**FOR PROVIDER TO COMPLETE ONLY IF PATIENT REFUSES TO SIGN ACKNOWLEDGEMENT:**

A good faith effort was made by \_\_\_\_\_ (provider name) to obtain written Acknowledgement of Receipt of the Notice of Privacy Practices from \_\_\_\_\_ (patient name), but he/she (or their representative or guardian) refused to sign such an acknowledgement for the following reason(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Provider Representative (Please Print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# ACKNOWLEDGMENT

## Form #663

### PURPOSE

The purpose of the Acknowledgement is to document, with a signature, that the patient or parent/guardian received a copy of the *Notice of Privacy Practices for Protected Health Information*.

### INSTRUCTIONS

This document serves as an acknowledgment of the Notice of Privacy Practices. It is signed and dated by the patient or parent/guardian.

If the patient refuses to sign the acknowledgment, contact the privacy official. The privacy official will answer any questions or concerns the patient may have.

Never refrain from treatment on a refusal to sign the acknowledgment. If the patient continues to refuse to sign the acknowledgment, document the efforts to explain the notice and subsequent failure to obtain a signature on the *Acknowledgment* form.

In emergency situations, i.e. natural disaster, or terrorist attack, services may be provided without a Notice of Privacy Practices and a signed *Acknowledgment*. However, upon their first visit to the clinic after the emergency has subsided, provide a Notice of Privacy Practices and ask them to complete the *Acknowledgment*.

### OFFICE MECHANICS AND FILES

File the patient's signed *Acknowledgment* in the patient's medical record.

### RETENTION PERIOD

Scan into patient's electronic medical record. Patient's record will be retained according to agency policy specified for the record type.

If there is no patient record, retain in file for six (6) years.