



Notice of Privacy Practices Acknowledgement Form
Facility: Christiana Dental Spa

I HAVE RECEIVED A COPY OF THE DMH NOTICE OF PRIVACY PRACTICES
[Omnibus Rule, Effective Date 3/26/13]

SIGNATURE:
DATE:

(This form must be signed by Individual or Personal Representative w/legal authority to make healthcare decisions)

If signed by a Personal Representative:

Print Name _____ **Role** _____
(Parent, Guardian, etc.)

Witness: _____ **Date:** _____

If the individual has a personal representative with legal authority to make healthcare decisions on the individual's behalf, the notice must be given to and acknowledgement obtained from the personal representative. If the individual or Personal Representative did not sign above, *staff must document when and how the notice was given to the individual, why the acknowledgement could not be obtained, and the efforts that were made to obtain it.*

Reason Individual or Personal Representative did not sign this form:

- Individual or Personal Representative chose not to sign.
- Individual or Personal Representative chose not respond after more than one attempt.
- Other _____.

Good Faith Efforts: The following good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than one attempt must have been made.

- Face to face presentation(s) _____
- Telephone contact(s) _____
- Mailing(s) _____
- Email _____
- Other _____

Staff Signature: _____ Title: _____
Print Name: _____ Date: _____

This form must be retained for a period of at least six years in the appropriate record in accordance with the DMH Privacy Handbook.