By signing this document, I acknowledge that I have received a copy of The Primary Care and Specialty Clinics of Liberty Hospital Notice of Privacy Practices and Patient Rights.

Patient Signature: ____________________________ Date__________ Time__________

Patient Representative/Relationship Signature:

_________________________________________________ Date__________ Time__________

Witness: _________________________________________ Date__________ Time__________

The Primary Care and Specialty Clinics of Liberty Hospital use only:

If the patient’s signature was not obtained, please describe reason why below:

☐ Patient refused to sign Acknowledgement.

☐ Patient unable to sign Acknowledgement due to emergent condition.

Other: Describe below:

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

The Primary Care and Specialty Clinics of Liberty Hospital is required by law to make a good faith effort to obtain a written acknowledgement from the patient receiving treatment regarding receipt of our Notice of Privacy Practices. A patient’s failure or refusal of this acknowledgement should not interfere with delivery of treatment. 45 CFR 164.520

The Primary Care and Specialty Clinics of Liberty Hospital is required to inform each patient of their patient rights in advance of providing or stopping care. 42 CFR 482.13.a (1) Interpretive Guidelines