Acknowledgment of Notice of Privacy Practices

Name: ______________________________

DOB: ______________________________

MRN: ______________________________

Please sign and date below to indicate that you have received a copy of the Cincinnati Children's Notice of Privacy Practices and an explanation of what it contains.

_______________________________________ Signature

_______________________ Date

_______________________________________ Name (Please Print)

Please check the appropriate relationship:

☐ Patient ☐ Parent ☐ Person Authorized to Consent ☐ Agency ☐ Other: ____________________

The following is to be completed by Cincinnati Children's personnel:

Please check the applicable box:

☐ The Notice of Privacy Practices was offered and accepted by the patient and the patient signed this Acknowledgment.

☐ The Notice of Privacy Practices was offered and accepted by the patient and the patient refused to sign the Acknowledgment.

☐ The Notice of Privacy Practices was offered and refused by the patient and the patient agreed to sign this Acknowledgment.

☐ The Notice of Privacy Practices was offered to and refused by the patient and the patient refused to sign this Acknowledgment.