SEARHC
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Our Notice of Privacy Practices describes in detail your health information rights and how your medical information may be used and disclosed. Federal law requires us to obtain acknowledgement that you have received our Notice of Privacy Practices.

Patient Declaration: I acknowledge that I have received SEARHC's Notice of Privacy Practices.

__________________________________ ____________________
Printed Name of Patient Date

__________________________________ ____________________
Signature of Patient (or personal representative) Date

__________________________________ ____________________
Printed Name of Personal Representative if applicable Date

This form will be retained in your health record

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Staff Use Only:

The patient or personal representative refused to sign this Acknowledgement.

__________________________________ ____________________
Employee Signature Date

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