UNIVERSITY OF VERMONT

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Printed Name _____ Date of Birth _____

I have received a copy of The University of Vermont's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by the University of Vermont and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

Patient/Legal Representative Signature _____ Date _____

If someone other than the patient is signing on behalf of the patient:

Legal Representative Printed Name _____ Relationship _____

******** DO NOT WRITE BELOW THIS LINE ********
TO BE COMPLETED BY DESIGNATED CLINIC STAFF PERSON IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of the Notice of Privacy Practices? ❑ YES ❑ NO

2. Briefly describe the efforts made to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices and check all that apply:

   ❑ Patient/Legal Representative refused to sign.

   ❑ There was an emergency situation that prevented the patient's/legal representative's ability to acknowledge receipt.

   ❑ Other (describe): _____