Acknowledgement of Notice of Privacy Practices

By signing this form, you acknowledge that you have received the Notice of Privacy Practices of MCPHS University (d/b/a 10 Optical; Forsyth Dental Hygiene Clinic; MCPHS University Balance, Movement, and Wellness Center; NESA Acupuncture Treatment Center; and The Eye and Vision Center). Our Notice provides information about how we may use and disclose the health and medical information that we maintain about you, as well as your rights and our duties with respect to your protected health information. We encourage you to read our full Notice. If you have any questions about our Notice of Privacy Practices that our registration staff cannot answer, please contact our HIPAA Privacy Officer at privacyofficer@mcphs.edu.

I acknowledge receipt of the Notice of Privacy Practices of MCPHS University.

Signature: _____
Individual or Personal Representative with legal authority to make healthcare decisions

Patient Name: _____ Date: _____

(If applicable)
Personal Representative Name: _____

Relationship to patient: _____

For Internal Use Only: Inability to Obtain Acknowledgment

If MCPHS University is not able to obtain a signature on the above acknowledgment, staff should record the good-faith effort made to obtain acknowledgment and the reason acknowledgment not obtained:

Effort to obtain acknowledgment:

- □ In-person request
- □ Request via mail (retain copy of letter for inclusion in patient's record)
- □ Request via email
- □ Other: _____

Reason acknowledgment was not obtained:

- □ Patient refused to sign
- □ Patient unable to sign
- □ Patient did not return acknowledgment via mail or email
- □ Other: _____

Staff Print Name/Title/Center:
_____/_____/_____

Staff Signature: _____ Date: _____