LIFEBRIDGE HEALTH
NOTICE OF PRIVACY PRACTICES:

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *LifeBridge Health Notice of Privacy Practices.* Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

I acknowledge receipt of the *LifeBridge Health Notice of Privacy Practices.*

Signature: ________________________________ Date: ________________________
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: ______________________ Date: ___________________

PATIENT ACCT #: ______________________