

Mission:
To protect, promote & improve the health
of all people in Florida through integrated
state, county & community efforts.



Rick Scott
Governor

Celeste Philip, MD, MPH
Interim State Surgeon General

Vision: To be the Healthiest State in the Nation

State of Florida
Department of Health
Notice of Privacy Practices Acknowledgement Form, DH 150-741, 09/13

Name _____ Client ID: _____

Facility/Site/Program: **Florida Department of Health in Nassau County**

I have received a copy of the DOH Notice of Privacy Practices Form DH 150-741, 09/13.

Signature: _____ Date: _____

Individual or Representative with legal authority to make health care decisions

If signed by a Representative:

Print Name: _____ Role: _____

(Parent, guardian, etc.)

Witness: _____ Date: _____

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgement obtained from the representative. If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgement could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices given to the individual on: Date: _____

Reason Individual or Representative did not sign this form:

- ____ Individual or Representative chose not to sign
- ____ Individual or Representative did not respond after more than one attempt
- ____ Email receipt verification
- ____ Other

<input type="checkbox"/> Face to face meeting
<input type="checkbox"/> Mailing
<input type="checkbox"/> Email
<input type="checkbox"/> Other

Good Faith Efforts: The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than one attempt must have been made.

- ____ Face to face presentation(s) _____
- ____ Telephone contact(s) _____
- ____ Mailings _____
- ____ Email _____
- ____ Other _____

Staff Signature _____ **Title:** _____

Print Name: _____ **Date:** _____

This form must be retained for a period of at least six years in the appropriate record.