

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



**Ron DeSantis**  
Governor

**Scott A. Rivkees, MD**  
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

____	Face to face meeting
____	Mailing
____	Email
____	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.**