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

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 __________________________________________________________________________

Print Name: ____________________________________________ Date: ____________________________

_____Face to face meeting
______Mailing
______Email
______Other

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