matrix
HOME HEALTH CARE

Receipt of Notice of Privacy Practices

Patient/Client Name: ______________________________ County: ____________, Florida

My signature on this form acknowledges that I have received a copy of the Agency's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by the Agency and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

____
PATIENT/CLIENT SIGNATURE

____
AUTHORIZED REPRESENTATIVE IF PATIENT/CLIENT CANNOT SIGN

____
WITNESS SIGNATURE

____
PRINT NAME OF AUTHORIZED REPRESENTATIVE

____
DATE

____
AUTHORIZED REPRESENTATIVE'S RELATIONSHIP TO PATIENT/CLIENT

▼ TO BE COMPLETED BY AGENCY REPRESENTATIVE IF FORM IS NOT SIGNED ▼

1. Was the client provided with a copy of the Agency's Notice of Privacy Practices?
   ❒ Yes ❒ No

2. Briefly describe efforts made to obtain the client's acknowledgment of receipt of the Notice and explain why the client was not able or willing to sign this form:

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Signature of Agency Representative

____
Date