Penn Medicine
Princeton Health

JOINT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By signing this form, I acknowledge that I have received a copy of Penn Medicine Princeton Health's Joint Notice of Privacy Practices.

Patient Name (Print): _____

Signature: _____ Date: _____

Personal Representative's Name (if applicable): _____

Personal Representative's Authority (e.g., parent, guardian, health care proxy):

_____

FOR STAFF USE ONLY

Complete this section if the acknowledgement form is not signed and dated by the patient or their personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Penn Medicine Princeton Health's Joint Notice of Privacy Practices but was unable to for the following reason:

- ❑ Patient refused to sign.
- ❑ Patient unable to sign.
- ❑ Other: _____

Employee Name: _____ Date: _____

Effective as of January 1, 2018.