The Christ Hospital
Cincinnati, Ohio 45219

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

R-5084 6/07

We are legally required to provide you with a copy of our **NOTICE OF PRIVACY PRACTICES** the first time you receive care at the Health Alliance. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

Patient or Patient's Legal Representative: Check appropriate box and sign.

❏ I have received a copy of the Notice of Privacy Practices.

❏ I have previously received a copy of the Notice of Privacy Practices.

❏ I do not want a copy of the Notice of Privacy Practices.

_____
PATIENT / LEGAL REPRESENTATIVE

_____ _____ _____
RELATIONSHIP TO THE PATIENT DATE TIME

Below this line is for HEALTH ALLIANCE staff use only if patient or patient's legal representative has not acknowledged above.

Associate: Check appropriate box and sign.

❏ Patient or Patient's Legal Representative refused to sign Acknowledgement.

❏ Patient or Patient's Legal Representative is unable to sign Acknowledgement.

❏ Patient or Patient's Legal Representative has previously acknowledged receipt of Notice of Privacy Practices.

_____ _____ _____
ASSOCIATE DATE TIME