

## **PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION**

**My signature below acknowledges the following:**

- I have received a copy/am aware of the **Patient Bill of Rights**; as required by law and have had an opportunity to receive assistance in understanding and exercising these rights.
- I have received a copy/am aware of this office's **Notice of Privacy Practices**, including the **Private Health Information (PHI)** designated at the time of visit.
- I have received information on/am aware of the Infection Control measures utilized by this organization.
- I have received a copy/am aware of the **Practice Disclosure (about our Practice, including the Grievance process)** and am comfortable with that information. I also understand this practices position on **Do Not Resuscitate (DNR) and Living Wills** and that this practice does not honor these directives.

Signature of Patient/Representative \_\_\_\_\_ Date \_\_\_\_\_

Above signature was not obtained because:

- Patient is unable and unaccompanied by a representative. Patient left with all pertinent disclosures.
- Patient refused to sign.
- Patient refused forms.