Excela Health
Physician Practices

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge that I received the Notice of Privacy Practices for Excela Health, which includes the Excela Health Physician Practices.

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Name of Patient

______________________________ ______________________
Signature of Patient (or patient's personal representative) — Date of receipt

Personal representative information (if applicable):

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Name of personal representative

____
Relationship to patient (or other authority)

**Please specify whom you may want protected health information released to other than yourself:
____
____

BELOW IS FOR USE BY EHPP ONLY

I provided the above named ☐ patient ☐ personal representative with the Excela Health Notice of Privacy Practices

Describe how notice was provided:

- ☐ Offered copy and individual refused to accept delivery
- ☐ Offered copy and individual accepted delivery
- ☐ Other____

Describe efforts to obtain signature on acknowledgement of notice form:

- ☐ Patient/personal representative was asked to sign form and refused.
- ☐ Other____

______________________________ ______________________
Signature of EHPP Representative — Date