



**FLORIDA HOSPITAL**  
*Memorial Medical Center*  
*HealthCare Partners*

**Acknowledgement of Receipt  
HIPAA Notice of Patient Privacy Practices**

By signing this Written Acknowledgement of Receipt for HIPAA Notice of Patient Privacy Practices (“Acknowledgement”), I hereby expressly acknowledge my receipt of HIPAA Notice of Patient Privacy Practices.

\_\_\_\_\_  
Patient, or Legal Representative, Signature

\_\_\_\_\_  
Printed Patient, or Legal Representative, Name (or label)

Date: \_\_\_\_\_

Acknowledgment NOT obtained because:

\_\_\_\_\_ Patient, or Legal representative, declined Notice of Patient Privacy Practices;

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Employee Printed Name

Date: \_\_\_\_\_