First In Flight Neurology
PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name:_____

Medical Record Number: _____ Social Security Number: _____

Date of Admission: _____ Notice Version (Date): _____

Acknowledgement of receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Privacy Practices Notice from:

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature:_____ Date:_____

□ Notice has previously been distributed by another location in our OHCA (except for physicians):

List locations that distributed the Joint Notice:_____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Individual : _____

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form: _____

_____

_____

Describe the reason why the individual would not sign this form: _____

_____

_____

SIGNATURE: (Hospital Representative)

I attest that the above information is correct.

Signature: _____ Date:_____

Print Name:_____ Title:_____

Include this acknowledgement form in the individual's records.

Patient Consent and Agreement:

- I consent to participation in the facility Patient Portal (Portal), and understand that my personal health and individually identifying information is made available to me in the Portal.
- I understand that the use of the Portal is for non-emergency purposes.
- I understand that I have the ability to provide Portal access to my Authorized Representatives (Representatives), and that those Representatives may have the ability to perform all of the functions I am able to perform, including viewing, downloading and transmitting my health and individually identifying information.
- I understand there are risks associated with web-based applications and that I am responsible for safeguarding my access information.
- I understand that my e-mail address is required to initiate Portal access, and will be used for communications related to the Portal. I agree to communicate my e-mail address changes.
- I have read and understand the Terms and Conditions of Use, and I have been provided with an opportunity to ask questions.
- I understand that my access to the Portal requires my acceptance of the Terms and Conditions of Use. If I refuse to sign at this time, I understand that I may change that decision in the future and can contact the Facility to obtain access to the Portal.
- I understand that failure to follow the Terms and Conditions of Use may result in termination of access to the Portal.

Patient Name		
Patient Signature	Date	Time

☐ Patient Refused Access to the Portal

Clinical Staff Signature (witness to refusal)	Date	Time

Patient Label