New Hanover Regional Medical Center

Name: _____ _____ _____
(Last Name) (First Name) (Middle Initial)
DOB: _____ MR# _____
Acct: _____

PATIENT ACKNOWLEDGMENT & INFORMATION LISTING INSTRUCTIONS (OUTPATIENT)

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE

1. I acknowledge that I have received or have been offered a copy of NHRMC's Joint Notice of Privacy Practices. _____ (Initial)

2. I acknowledge my right and have been offered the option to request to receive communications of my personal health information by alternative means or at alternative locations. I understand that NHRMC may refuse to accommodate my request if it is not reasonable. _____ (Initial)

PRIVACY INSTRUCTIONS

Yes ☐ **No** ☐ May we discuss details regarding your care, your test results, billing information, or appointment information with someone else, other than you? If yes, please list the name and relationship of each individual below.

	Name	Relationship
1.		
2.		
3.		

Yes ☐ **No** ☐ May we leave detailed messages on your answering machine or voice mail (e.g. test results)? If so, what phone number should we use for this purpose?
Please provide: _____

_____ _____
Signature of Patient or Representative Date

_____
Print Name

_____
Relationship of Representative / authority to act on behalf of the Patient

FOR NHRMC Staff USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

_____

_____

THIS FORM PART OF PERMANENT MEDICAL RECORD