New Hanover Regional Medical Center

Name: ______________ ______________ ______________
(Last Name) (First Name) (Middle Initial)

DOB: ______________ MRN#: ______________

HAR#: ______________ CSN#: ______________

PATIENT ACKNOWLEDGMENT & INFORMATION LISTING INSTRUCTIONS (INPATIENT)

(Inpatients, Surgical/Pre-Admission Testing, OPSU, ED/ER)

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)

PATIENT INFORMATION LISTING INSTRUCTIONS

I do ☐ / do not ☐ want my name, location, general condition, and religious affiliation released as part of NHRMC's patient information listing. I understand that if I do not consent to the disclosure, information on my behalf will not be released to visitors such as family and friends, outside phone callers, florists, and members of the clergy, etc. Visitors and phone calls are allowed, but I will be responsible for providing the information.

OPTIONAL FAMILY/FRIEND LIST FOR TELEPHONE DISCLOSURES OF DETAILED CONDITION INFORMATION DURING THIS HOSPITALIZATION

	Name	Relationship
1.		
2.		
3.		

I understand that the individuals identified above must provide the following code word to NHRMC before information will be provided, and that I am responsible for notifying them of this code word: ______________ .
(code word)

Patient Name (printed) ______________ Representative Name (printed) ______________

Relationship to Representative/ Authority to act on behalf of the Patient ______________ Reason patient could not sign for him/herself ______________

Signature of Patient or Representative ______________ Date ________ Time ________

Witness Name (printed) ______________ Date ________ Time ________

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:

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THIS FORM PART OF PERMANENT MEDICAL RECORD

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Privacy Acknowledgment