A.C.T. HOME CARE, INC.
1075 Gaines School Rd
Athens, GA 30605
Ph (706) 559-4432, Fax (706) 559-4498
Toll Free (866) 559-4432

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form will be retained in your medical record.

Name of Client/Patient/Employee _____ Date of Birth _____

By my signature below, I _____, acknowledge that I received a copy of A.C.T. Home Care, Inc. Notice of Privacy Practices. I hereby designate the following individual(s) to receive communications from A.C.T. Home Care, Inc. that may include health information about me: **Hospitals, Physicians, the PRO, state agencies, and/or federal agencies. I authorize release of my medical records to/from the hospital, my physician(s), the PRO, other agencies and/or federal agencies.** I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for the period necessary to complete all transactions on matters related to services provided to me. I understand that unless otherwise limited by State or Federal regulation, and except to the extent that action has been taken based upon it, I may withdraw this authorization at any time.

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Signature of patient (or personal representative) _____ Date _____

**If this acknowledgement is signed by a "personal representative" on behalf of the patient, complete the following:** (a Personal Representative is the patient's healthcare decision maker if the person cannot act for themselves. It can be, for example, the parent, legal guardian, healthcare surrogate):

Personal Representative's Name: _____

Relationship to Patient: _____

I authorize A.C.T. Home Care, Inc. to leave voice mail messages concerning my health information (i.e., Lab results, appointment instructions, etc.) at the following number: phone (  ) _____

Patient's initials: _____

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FOR OFFICE USE ONLY

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I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- An emergency situation prevented us from obtaining acknowledgement (Please specify)
- Other (Please specify)

_____

Employee or Agent of employer taking information above must sign and date their name.

Name of Employee/Agent (print) _____ Signature of Employee/Agent _____ Date _____

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