****

**ACKNOWLEDGEMENT FORM**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Medical Records #: | | | | | | | | | | | |  | | | | | | |
|  | | | | | | | | | | | |  | | | | | | |
| Patient’s Name: | | |  | | | | | | | Date of Birth: | | / | | | / | |  | |
|  | | | | |  | | | | | | | Day | | | Month | | Year | |
|  | | | | | | | | | | | | | | | | | | |
| We are required by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you. | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Signature: |  | | | | | | | | Date: | | | | |  | | | | |
|  | | (Patient or Authorized Representative) | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Relationship to patient: | | | |  | | Self | |  | | | Spouse | |  | | | Other: | |  |
|  | | | | | | | | | | | | | | | | | | |
| Reason Patient Unable/ Unwilling to Sign: | | | | | | |  | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
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**ACKNOWLEDGEMENT FORM**

DOCUMENTO DE RECONOCIMIENTO DE COLUMBUS REGIONAL HEALTH NETWORK

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Numero de Registro Medico: | | | | | | | | | | | |  | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | |
| Nombre del Paciente: | | | |  | | | | | Fecha de Nacimiento: | | | | | / | | | / | |  |
|  | | | | | |  | | | | | | | | Dia | | | Mes | | Ano |
|  | | | | | | | | | | | | | | | | | | | |
| La ley nos requiere que nosotros le proveamos a usted con nuestro Aviso de Practicas de Privacidad las cuales explican como podemos usar y divulgar su imformacion medica. La ley tambien nos requiere que obtengamos su firma, reconociendo que este aviso lo hemos hecho disponible para usted. | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Firma: |  | | | | | | | | | Fecha: | | | | |  | | | | |
|  | | (Paciente o Representate Authorizado) | | | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| Relacion al Paciente: | | |  | | Mismo | | |  | | | Esposo (a) | |  | | | Otro: | |  | |
|  | | | | | | | | | | | | | | | | | | | |
| Razon Por la Cual El Paciente No Desea Firmar: | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |