Baptist Health South Florida

PATIENT ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I acknowledge that I was provided with a copy of the Baptist Health Notice of Privacy Practices describing how Baptist Health may use and disclose my health information under the federal law. Provided that Baptist Health continues its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health information for the purposes and activities permitted under the federal privacy law, which are described in the Baptist Health Notice of Privacy Practices.

_____ _____

Patient Name Date

_____ _____

Signature of patient or personal representative If personal representative, personal representative's authority to act

For BHSF facility only:

The date that you requested the signature and date: _____

The reason that the signature and date were not obtained: _____

Acceptable reasons for not obtaining acknowledgement:

☐ Unconscious ☐ Deceased

☐ Transferred ☐ Patient refused

☐ Other/please describe: _____

_____

_____

_____

Baptist Health South Florida

NOTIFICACIÓN DE PRACTICA DE PRIVACIDAD Y DIVULGACIÓN DE INFORMACIÓN

Reconozco que he recibido una copia que notifica las Prácticas de Privacidad de salud del Baptist, describiendo como el Baptist Health, según la ley federal puede utilizar y dar a conocer información sobre mi salud. Siempre y cuando el Baptist Health continúe esforzandose en Buena fe por cumplir con los requisitos de la ley federal de privacidad, consiento mediante el presente a que se utilice y se de a conocer información sobre mi salud para los propósitos y actividades permitidos por la ley federal de privacidad, la cuál se describe en la Notificación sobre las Prácticas de Privacidad de Baptist Health.

_____ _____

Nombre de Paciente Fecha

_____ _____

Firma del paciente o representante Si es representante personal, el representante autoriza a actuar

For BHSF facility only:

The date that you requested the signature and date: _____

The reason that the signature and date were not obtained: _____

Acceptable reasons for not obtaining acknowledgement:

☐ Unconscious ☐ Deceased

☐ Transferred ☐ Patient refused

☐ Other/please describe: _____

_____

_____

_____