



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient's Name: _____

Address: _____

Facility Name: _____

Upon request, I will be given a copy of Worthington Optimal Wellness's *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that Worthington Optimal Wellness has the right to change this *Notice* at any time. I may also obtain a current copy by contacting Worthington Optimal Wellness's Privacy Official, or by visiting the Worthington Optimal Wellness's web site at www.worthingtonoptimalwellness.com.

My signature below acknowledges that I have been offered a copy of the *Notice of Privacy Practices*:

Signature of Resident or Personal Representative Date

Print Name

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the *Acknowledgement*:

Completed by:

Signature of Facility Representative Date

Print Name