Fecha: _____
MRN (o Fecha de nacimiento): _____
Nombre: _____

CONFIRMACIÓN DE RECEPCIÓN DE NOTIFICACIÓN DE PRÁCTICAS DE PRIVACIDAD

Yo acuso recibo de copia de la Notificación de Prácticas de Privacidad del Sistema de Salud Henry Ford.

_____
Firma o iniciales del paciente o su representante autorizado*

_____
Nombre en letra de imprenta del representante autorizado (si aplica)

*Representantes autorizados incluyen:

- Padres de un Menor
- Guardián o Tutor Legal
- Representante Personal
- Cualquier persona bajo Poder Notarial médico permanente medical (POA)

Para el Guardián Legal, Representante Personal o persona con autoridad bajo un poder notarial médico duradero, una copia de la documentación apropiada puede ser necesaria.

FOR HFHS USE ONLY

For Workforce Member Use Only

Document Good Faith Effort:
☐ Offered Notice & Acknowledgement to Patient or Representative
☐ Offered to secure an interpreter to present Notice and Acknowledgement to Patient or Representative
☐ Other: _____

If good faith effort is unsuccessful and Acknowledgement is not obtained, document your efforts and reason why the acknowledgement was not obtained:

Reason Acknowledgement was not obtained:
☐ Patient Unable to Sign/Notice Given to Caregiver
☐ Incapacitated Patient/No Patient Representative Present/Emergency Treatment
☐ Patient/Representative Declined to Receive Notice
☐ Patient/Representative Declined Interpreter
Other: _____

Workforce Member Signature: _____

Date of attempt to obtain Acknowledgement: _____

Upon completion scan or file in the patient's record. If form needs to be emailed or faxed, please do so at IPSO@hfhs.org or (313) 874-9449. If form needs to be mailed, please send it to Information Privacy & Security Office, 1 Ford Place, Suite 2A, Detroit, MI 48202.