

# GUTHRIE HEALTH

## NOTICE OF PRIVACY PRACTICES

### ACKNOWLEDGEMENT OF RECEIPT

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By signing this form, you acknowledge receipt of the NOTICE OF PRIVACY PRACTICES of Guthrie Health. Our NOTICE OF PRIVACY PRACTICES provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our NOTICE OF PRIVACY PRACTICES is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by: (accessing our website at [www.guthrie.org](http://www.guthrie.org) / contacting our organization at 1-866-265-9974).

If you have any questions about our NOTICE OF PRIVACY PRACTICES, please contact:

Privacy Office  
Guthrie Health  
One Guthrie Square  
Sayre, PA 18840  
Telephone: 1-866-265-9974

I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES of Guthrie Health.

Patient's Name: \_\_\_\_\_  
(please print legibly)

Medical Record Number: \_\_\_\_\_

Signature: \_\_\_\_\_  
(patient/parent/guardian)

Date: \_\_\_\_\_

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#### FOR STAFF USE ONLY IF NO SIGNATURE OBTAINED.

#### INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Reason: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_  
(Guthrie Health representative)

Date: \_\_\_\_\_