

State of Florida  
Department of Health



**Notice of Privacy Practices Acknowledgment Form**

Name: \_\_\_\_\_ Client ID# \_\_\_\_\_

Facility/Site/Program: \_\_\_\_\_

I have received a copy of the DOH Notice of Privacy Practices Form DH 150-741, 09/13.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Individual or Representative with legal authority to make health care decisions

**If signed by a Representative:**

Print Name: \_\_\_\_\_ Role: \_\_\_\_\_  
(Parent, guardian, etc.)

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

If the individual has a representative with legal authority to make health care decisions on the individual's behalf, the notice must be given to and acknowledgment obtained from the representative. *If the individual or representative did not sign above, staff must document when and how the notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.*

Notice of Privacy Practices given to the individual on \_\_\_\_\_ date

<input type="checkbox"/>	Face to face meeting
<input type="checkbox"/>	Mailing
<input type="checkbox"/>	Email
<input type="checkbox"/>	Other _____

**Reason Individual or Representative did not sign this form:**

- Individual or Representative chose not to sign
- Individual or Representative did not respond after more than **one** attempt
- Email receipt verification
- Other \_\_\_\_\_

**Good Faith Efforts:** The following good faith efforts were made to obtain the individual's or Representative signature. Please document with detail (e.g., date(s), time(s), individuals spoken to and outcome of attempts) the efforts that were made to obtain the signature. More than **one** attempt must have been made.

- Face to face presentation(s) \_\_\_\_\_
- Telephone contact(s) \_\_\_\_\_
- Mailing(s) \_\_\_\_\_
- Email \_\_\_\_\_
- Other \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Print Name: \_\_\_\_\_

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