

**HERITAGE VALLEY HEALTH SYSTEM
CORPORATE COMPLIANCE PROGRAM
Receipt of Notice of Privacy Practices
Acknowledgement Statement**

I acknowledge I have received a copy of Heritage Valley Health Systems Notice of Privacy Practices for Protected Health Information.

Patient Name (*please print*)

Patient Signature

Date

In the event of the patients emergency condition, signature of person receiving Notice for patient.

If I am unavailable, I authorize the release of test results and treatment plans to be discussed with:

Name

Phone

Relationship

Patient Signature: _____ **Date:** _____