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

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Patient Name *(please print)* Date of Birth

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Patient Signature Date

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

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List the family members (if any) whom we may inform about your healthcare and payment related to your healthcare.

Name: ____________________ Relationship: ____________ Phone: ____________

Name: ____________________ Relationship: ____________ Phone: ____________

List all the family members, or other persons (if any) whom are authorized to pick up healthcare information such as medical records, prescriptions, supplies, test results, etc on your behalf.

Name: ____________________ Relationship: ____________ Phone: ____________

Name: ____________________ Relationship: ____________ Phone: ____________

Print the phone number(s) you would like to receive calls about your appointments, lab and x-ray results.

____________________ May we leave a detailed message at this number? ☐ Yes ☐ No

____________________ May we leave a detailed message at this number? ☐ Yes ☐ No