Uniquely connected. For life.℠
HERITAGE VALLEY
Health System

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)*

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Patient Signature

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Date

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

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

Name	**Phone**	**Relationship**
______________________________	__________________	______________________
______________________________	__________________	______________________
______________________________	__________________	______________________

Patient Signature: ____**Date**: __________________