



431 Savannah Road, 1st Floor
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Phone: (302) 644-9080
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Acknowledgement of Receipt of Privacy Practices

I acknowledge that I have received and understand DelMed Health's *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that DelMed Health may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy of DelMed Health's *Notice of Privacy Practices* by submitting a request in writing for a current copy of DelMed Health's *Notice of Privacy Practices* or by accessing www.delmedhealth.com.

Printed Patient Name

Patient Signature

Date

If completed by parent or guardian if patient is under 18 years of age or patient's representative, please print and sign below.

Printed Patient Personal Representative Name

Relationship to Patient

Patient Personal Representative Signature

Date

For DelMed Health's Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

DelMed Health made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- Patient or patient's personal representative refused to sign
- Patient or patient's personal representative was unable to sign
- Other: _____

Printed Employee Name

Employee Signature

Date