Gwinnett Health System

PLACE LABEL HERE

NOTICE PRIVACY PRACTICES and PERSONAL REPRESENTATIVE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NPP):

My signature below acknowledges that I have received or have been offered a copy of Gwinnett Health System's (GHS) Notice of Privacy Practices, and I am aware that I have access to this document on the health system's website at www.gwinnettmedicalcenter.org.

OR

In an emergency treatment situation, obtain the NPP acknowledgement as soon as it is reasonably practicable to do so after the emergency situation has ended.

___The Patient is unable to sign because (check one) ❑ Patient is Critical or Unconscious. ❑ Patient Refuses to Sign.

___CERTIFICATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (NPP): I hereby certify that as an associate or agent of GHS, I have made a good faith effort to obtain from the patient or the patient's authorized representative a written acknowledgment of the GHS NPP in accordance with its Provision of Notice of Privacy Practices (policy #100-105).

DESIGNATION OF PERSONAL REPRESENTATIVE:

As a patient, you may designate one or more personal representatives. A personal representative may receive Protected Health Information (PHI) about you. PHI includes information about your current medical condition and diagnosis, treatment and prognosis, and billing and payments. Personal representatives will not have access to PHI in the periods that are between treatments or admissions. My personal representative(s) is listed below and my signature of approval.

A personal representative may be a spouse, relative, domestic partner, or friend. You can remove or add personal representatives at any time, including during treatment or upon another admission to a GHS facility.

_____ (initial) I (Patient) **do not** wish to designate a personal representative. I understand that the hospital's healthcare team may designate an interim personal representative, if designating a personal representative will expedite or enhance my care as a patient.

I (Patient) designate the following as my personal representative(s):

_____________________________________ *(Name of Personal Representative)* _______________ *(Relationship)*

_____________________________________ *(Address, if known)* _______________ *(Telephone number)*

_____________________________________ *(Name of Personal Representative)* _______________ *(Relationship)*

_____________________________________ *(Address, if known)* _______________ *(Telephone number)*

_____________________________________ (Name of Personal Representative) _______________ (Relationship)

_____________________________________ (Address, if known) _______________ (Telephone number)

_____________________________________ Patient or Authorized Representative Signature

_______________/_______________ Patient Telephone Number (home/cell)

_______________ Date

_____________________________________ _______________ _____________________________________

1-32434 FORM 1-32434 REV. 02/2013

PLACE LABEL HERE

NOTICE PRIVACY PRACTICES and PERSONAL REPRESENTATIVE

GHS Representative Name Department Position