

Medical Record Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

**BY SIGNING BELOW, I HEREBY ACKNOWLEDGE  
RECEIPT OF THIS PRIVACY NOTICE.**

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Patient's Representative

\_\_\_\_\_  
Printed Name of Patient's Representative (if applicable)

\_\_\_\_\_  
Representative's Relationship to Patient (if applicable)

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After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of USA Health System Representative

\_\_\_\_\_  
Date

**The effective date of this notice is April 1, 2006.**