Friendsview
RETIREMENT COMMUNITY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Resident Name: _____ Medical Record No. _____
Address:
_____ _____

ORGANIZATION Name: Friendsview Retirement Community

I have been given a copy of Friendsview Retirement Community's *Notice of Privacy Practices ("Notice"),* which describes how my health information is used and shared. I understand that Friendsview Retirement Community has the right to change this *Notice* at any time. I may obtain a current copy by contacting the ORGANIZATION Privacy Official, or by visiting Friendsview Retirement Community's web site at www.friendsview.org.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of Resident or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Friendsview Retirement Community's Use Only:
Complete this section if you are unable to obtain a signature.

1. If the resident or personal representative is unable or unwilling to sign this *Acknowledgement,* or the *Acknowledgement* is not signed for any other reason, state the reason:
   _____
   _____
   _____
   _____

2. Describe the steps taken to obtain the resident's (or personal representative's) signature on the Acknowledgement*:*
   _____
   _____
   _____
   _____

Completed by:

_____ _____
Signature of ORGANIZATION Representative Date

_____
Print Name

File original in resident file in the business office.