JEFFERSON COMMUNITY
Health & Life

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE

I have had the opportunity to receive a copy of Jefferson Community Health and Life Hospital/Clinic's Notice of Privacy Practices. I understand that JCHL has the right to change its Notice of Privacy Practices from time to time and that I may contact JCHL at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name (please print) Date of Birth

INDIVIDUALS INVOLVED IN PATIENT CARE OR PAYMENT

Jefferson Community Health and Life Hospital/Clinic may disclose your relevant medical information to family members or others you designate who are involved in your care or payment for your care, we ask each patient to designate in writing those individuals who may receive information relating to your medical care or payment at JCH&L. For example, we may give lab or other test results by phone to such individuals when you are not available.

DESIGNATION OF INDIVIDUALS APPROVED TO RECEIVE MEDICAL INFORMATION

I designate the following individuals to receive information regarding my care, or payment for my care at Jefferson Community Health and Life Hospital/Clinic

□ BILLING INFORMATION ONLY □ ALL □ I WISH TO MAKE NO DESIGNATION AT THIS TIME

Name	Date of Birth	Relationship to Patient	Phone Number
Name	Date of Birth	Relationship to Patient	Phone Number
Name	Date of Birth	Relationship to Patient	Phone Number

I understand that I must update this form if my circumstances or preferences change.
I understand that this form does not alter JCH&L's ability to communicate with individuals involved in my care that are not designated above in the event of an **emergency** or other circumstance where I am unavailable and, in JCH&L's professional judgement, JCH&L believes it is in my best interest to do so.

Documentation of Good Faith Effort

For clinic/hospital personnel use only

For use When Acknowledgement Cannot be Obtained

□ Patient refused to sign
□ Patient was unable to sign or initial because _____
□ Patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity

X _____
Signature of Clinic/Hospital Personnel Date

X _____
Signature of Clinic/Hospital Personnel Date

Patient/Representative Signature Date

Updated 7/22/21