JEFFERSON COMMUNITY
Health & Life

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE

Updated 04/05/2022

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 JCH&L has the right to change its Notice of Privacy Practices from time to time and that I may contact JCH&L at any time to obtain a current copy of the Notice of Privacy Practices. 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 below 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.*

_____

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 you 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.

DESIGNATION OF EMERGENCY CONTACTS

I designate the following individuals to be contacted in any case of an emergent situation with my care at Jefferson Community Health and Life Hospital/Clinic.

Please list your designations below and mark the appropriate roles for each contact:

_____

NAME DATE OF BIRTH RELATIONSHIP PHONE NUMBER

☐ BILLING INFORMATION ☐ MEDICAL INFORMATION ☐ EMERGENCY CONTACT ☐ ALL

_____

NAME DATE OF BIRTH RELATIONSHIP PHONE NUMBER

☐ BILLING INFORMATION ☐ MEDICAL INFORMATION ☐ EMERGENCY CONTACT ☐ ALL

_____

NAME DATE OF BIRTH RELATIONSHIP PHONE NUMBER

☐ BILLING INFORMATION ☐ MEDICAL INFORMATION ☐ EMERGENCY CONTACT ☐ ALL

X_____

PATIENT/REPRESENTATIVE SIGNATURE **DATE**

FOR CLINIC/HOSPITAL PERSONNEL USE ONLY WHEN ACKNOWLEDGEMENT CANNOT BE OBTAINED

Documentation of Good Faith Effort

- PATIENT REFUSED TO SIGN
- PATIENT WAS UNABLE TO SIGN OR INITIAL BECAUSE._____
- PATIENT HAD A MEDICAL EMERGENCY, AND AN ATTEMPT TO OBTAIN THE ACKNOWLEDGEMENT WILL BE MADE AT THE NEXT AVAILABLE OPPORTUNITY.

_____

Signature of Hospital/Clinic staff Date

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Signature of Hospital/Clinic staff Date