



1215 East Michigan Avenue
P.O. Box 30480
Lansing, Michigan 48909-7980

Notice of Privacy Practices Acknowledgement

I acknowledge that:

A copy of the Sparrow Health System's Notice of Privacy Practices was made available to me at the location where I received health care services.

The *Notice of Privacy Practices* was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices.

I know that I can ask for a copy of the *Notice of Privacy Practices* to take with me.

If I came in for health care services in an emergency treatment situation, I was able to view the *Notice of Privacy Practices* as soon as reasonably practicable after the emergency treatment situation.

Printed name of patient or patient's representative

Signature of patient or patient's representative

Date

Relationship to patient (if other than patient)

Complete only if patient or representative signs by use of a mark:

Printed name of witness

Signature of witness

Date

Printed name of witness

Signature of witness

Date

[If the above signature is that of a patient's representative, Sparrow must complete the following.]

Sparrow has verified the identification of _____ (patient's representative name) by _____
_____ (type of verification, e.g., driver's license) and that in his/her capacity of _____
_____ (description of authority to act, e.g. legal guardian, patient authorized
representative, power of attorney for medical care including medical records, executor of estate).

Verification completed by:

Associate name and signature

Date

TO BE COMPLETED BY SPARROW HEALTH SYSTEM

If an acknowledgment is not obtained, describe Sparrow Health System's good faith efforts to obtain the acknowledgment and the reason why the acknowledgment was not obtained.
