

**BOSTON UNIVERSITY  
REHABILITATION SERVICES**

**Privacy Notice Written Acknowledgement**

**Patient Name:** \_\_\_\_\_ **Record Number:** \_\_\_\_\_  
(Last) (First) (Middle)

I understand that the Rehabilitation Services may use my health information for treatment, payment and health care operations. I have been given a copy of the Rehabilitation Services' Notice of Privacy Practices that describes how my information is used and disclosed. I understand that the Rehabilitation Services has the right to change this Notice at any time. I may obtain a current copy of the Notice by contacting the Records Administrator for Rehabilitation Services (the location where I received my health care services).

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian or  
Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by Personal Representative,  
Date  
relationship to patient

\_\_\_\_\_  
April 14, 2003  
Privacy Notice Effective

\_\_\_\_\_  
Witness

**DOCUMENTATION OF GOOD FAITH EFFORT**

Notice of Privacy Practices and Written Acknowledgement provided to the patient/parent/ legal guardian or other personal representative, by:

- Hand delivery,
- Sent to the patient/parent/legal guardian at the address of record, or
- Sent to the patient/parent/legal guardian at the Email address of record

Patient/parent/legal guardian or other personal representative :

- Expressly states they decline to sign Written Acknowledgement of receipt of Notice because \_\_\_\_\_
- Has not expressly declined, but has failed to return the signed Written Acknowledgement, despite the following good faith efforts to obtain the return of the Acknowledgement:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date