



Arkansas Valley Accumed  
NCPDP: 0613554  
226 Main St  
Ordway, CO 810631403  
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2021

PAAS National® Health Care FWAC Policy & Procedure Manual

## Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Arkansas Valley Accumed's Notice of Privacy Practices.

_____ Name of Patient (Please Print)	____/____/____ Date of Birth
_____ Signature of Patient or Personal Representative	____/____/____ Date
_____ Name of Personal Representative (Please Print)	_____ Relationship to Patient

### Documentation of Good Faith Effort to obtain acknowledgment of receipt of Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient)

I hereby certify that on \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy), I made a good faith effort to obtain the above patient's written acknowledgement of his/her receipt of Arkansas Valley Accumed Notice of Privacy Practices. However, such acknowledgment was not obtained because:

- ☐ Patient refused to sign
- ☐ Patient was unable to sign or initial because:  
\_\_\_\_\_
- ☐ The Patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ A copy of the Notice was **MAILED / E-MAILED** (circle one) to most recent address on file.
- ☐ Other Reason:  
\_\_\_\_\_

_____ Printed name of employee completing form	____/____/____ Date
_____ Signature of employee completing form	

*\*Per HIPAA documentation requirements pharmacy must keep the patient's signature acknowledging receipt of Notice of Privacy Practices for a minimum of six years.*

## Request to Access or Release