



MeritCare Health System  
PO Box MC  
Fargo, ND 58122-0010

<b>Patient's Name</b>
_____
<b>Patient's Medical Record Number</b>
_____
<b>Patient's Date of Birth (mm/dd/yyyy)</b>
____ / ____ / ____
(Or Affix Label)

### ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a written copy of the **MeritCare Health System Notice of Privacy Practices**. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be a part of my record until such time as I may choose to revoke this acknowledgment. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Authorized Agent

#### TO BE COMPLETED BY MERITCARE IF NO ACKNOWLEDGMENT CAN BE OBTAINED:

Good faith efforts were made to obtain acknowledgment from the patient or patient's authorized agent. The good faith efforts made, and the reason acknowledgment could not be obtained, were:

- Patient (or authorized agent) refused to sign after being requested to do so
- Minor presented without parent or authorized agent. NPP, acknowledgement form, and self addressed envelope sent home with patient.
- Other: (please describe) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of MeritCare Associate

\_\_\_\_\_  
Date