



**UNIVERSITY OF NORTH DAKOTA
Bismarck Center for Family Medicine
701 E. Rosser Ave
Bismarck, North Dakota 58501
701-751-9500 701-751-9508**

**ACKNOWLEDGEMENT
OF
NOTICE OF PATIENT PRIVACY PRACTICES**

Effective April 14, 2003

I acknowledge that I have received a written copy of the University of North Dakota Bismarck Center for Family Medicine Notice of Patient 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 part of my record until such time as I may choose to revoke this acknowledgement. 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 THE BISMARCK CENTER FOR FAMILY MEDICINE
STAFF IF
NO ACKNOWLEDGEMENT CAN BE OBTAINED**

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

Patient (or authorized agent) refused to sign Notice of Privacy Practices.

Other (please describe): _____

Signature of Bismarck Center for Family Medicine Privacy
Officer

Date