

Florida Medical Supply Pharmacy

NOTICE OF PRIVACY PRACTICES

Record of Acknowledgment / Documentation of Good Faith Effort to Obtain Acknowledgment

Name of [Resident/Patient]: _____ Date: _____

Effective Date of This Privacy Notice

The effective date of this Privacy Notice is April 14, 2003

Contact Information for Questions, Complaints or Requests Regarding Your Health Information

Should you have any questions concerning our privacy practices, obtaining a copy of our privacy notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your protected health information, obtaining an accounting of our disclosures of your protected health information, requesting inspection or copying of your medical information, requesting that we communicate information about your health matters in a certain way, filing complaints, or any other concerns you may have relative to our privacy practices, please contact:

-Gary M. Posey: "HIPAA Compliance Officer"
5314 – A Frank Hough Road, Panama City, FL 32404
1-850-785-1900 phone, 1-850-913-9352 fax
www.fmspharmacy.com

If you wish, you may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. You may mail your complaint to U.S. Department of Health and Human Services, 200 Independence Avenue S. W., Washington, DC 20201; or you may call 1-202-619-0257 or 1-877 696-6775; or you may log on to the internet address, <http://www.hhs.gov/ocr>

Acknowledgment / Good Faith Effort to Obtain Acknowledgment (check one of the following)

☐ I certify that I received a copy of the above-named entity's Privacy Notice and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting my health information.

Date: _____ Signature (Resident): _____

Printed Name: _____

☐ I certify that I am the authorized representative of the above-identified patient, and that I have received the Privacy Notice on behalf of this individual and that the above-named entity provided me with an opportunity to review this document and ask questions to assist me in understanding the patient's privacy rights. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting health information.

Date: _____ Signature of Representative: _____

Printed Name: _____

Relationship to Individual: _____

☐ I, _____, certify that I made a good faith effort to obtain the acknowledgment of the above-identified [resident/patient] or his/her personal representative that he/she had received a copy of the Privacy Notice of the above-identified entity, but was unable to obtain such acknowledgment for the following reason(s):

☐ (Resident/Patient) or personal representative refused to sign.

☐ (Resident/Patient) or personal representative was unavailable to sign.

☐ Other: _____

Date: _____ Signature/Title: _____

A copy of this document must be provided to the person to whom the Privacy Notice was provided and a copy must be filed in the patient's record.