Ambulatory Patient Notification Record

I acknowledge that I have been given the following Notices and forms, as required by State and Federal regulations where appropriate:

- New York State Patient's Bill of Rights
- New York State Parent's Bill of Rights
- Patient's Responsibilities
- Notice of Privacy Practices
- Health Information Exchange (HIE) and Healthix Consent Form
- An Important Message From Medicare About Your Rights
- New York State Health Care Proxy Form
- Summary of Policy on Advance Directives
- Patient Information on Pain Management
- Appendix & Glossary

By signing below, I acknowledge that I have been provided a copy of the aforementioned Notices and Appendixes, when applicable, and have therefore been advised about my rights and responsibilities as a patient, any options available to me regarding advance directives, of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information.

_____
Print Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority

I was not able to obtain the patient's acknowledgement of receipt of the foregoing Notices upon registration because:

- The patient refused to sign, despite good faith efforts;
- The patient was unaccompanied and not alert or oriented;
- The patient was unaccompanied and needed emergency care;
- Other: _____.

Employee signature: _____ Employee Title: _____

Print Name: _____ Date: _____