Lakeland Regional Health®

NOTICE OF PRIVACY PRACTICES
Acknowledgment of Receipt

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Lakeland Regional Health Systems, Inc. and Lakeland Regional Medical Center, Inc. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices also contains a section that explains our nondiscrimination policy and how we comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We encourage you to read the Notice of Privacy Practices in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing our website at myLRH.org or from Planning and External Relations, Lakeland Regional Medical Center, P.O. Box 95448, Lakeland, Florida 33804.

If you have any questions about our *Notice of Privacy Practices*, please contact the Director of Health Information Management Services at 863.687.1100, ext. 1415, or at P.O. Box 95448, Lakeland, Florida 33804.

I acknowledge receipt of the Notice of Privacy Practices of Lakeland Regional Medical Center, and Lakeland Regional Health Systems, Inc.

_____ _____

Signature of Patient, Parent, Conservator or Guardian | Date / Time

To be completed only if no signature obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained.

_____ _____

Signature of Provider Representative | Date / Time