

DeKalb County Rehab and Nursing Center (DCRNC)
Acknowledgement of Receipt of Notice of Privacy Practices

Print Name of Resident

I have received a copy of DCRNC's Notice of Privacy Practices.

Signature of Resident/Resident's Representative

Date Signed

Print name of the above signed individual

I request the following restrictions to the use or disclosure of my health information:
(If no restrictions please write "None")

Please check the box Yes or No to the statements below:

I give my consent: To have my name and room number in a directory in the lobby and on the nursing units. Yes No

I give my consent To DeKalb County Rehab and Nursing Center to utilize or disclose protected health information (PHI) to third parties as may be required to carry out treatment, payment or healthcare operations. Such disclosure will be limited to third parties whose sole purpose is the performance of functions related to your stay at the Facility. Examples include pharmacies that supply medications on your behalf; medical supply companies; Medicare; insurance, Illinois Public Aid; Trans VAC; rehabilitation therapy providers, consultants charged with specific responsibilities for your care.
 Yes No

I give my consent: To DCRNC to take a photo for identification purposes at DCRNC. Yes No

I give my consent: To have my picture taken while participating in special activities. These may be used for newspaper releases concerning DCRNC. Yes No

I give my consent: To post my picture in the facility. Yes No

I give my consent: To print my picture in the Gazette the nursing units. Yes No

I give my consent: To possibly have my name or birthdate (no year) given to social organizations, or religious organizations. Yes No

I give my consent: To announce my birthday (not the year). Yes No

I give my consent: To post my birthday (not the year). Yes No

I give my consent: To print my birthday (not the year). Yes No

I authorize the specific use of my protected health information as described in the Privacy Practice Notices.

Signature of Resident/Resident's Representative

I give my consent for the DeKalb County Rehab and Nursing Center Foundation to place my name, the names of family or friends on a mailing list designed to raise funds solely for DCRNC.

Signature of Resident/Resident's Representative

For Facility Use Only

Response of facility: _____ Restrictions accepted _____ Restrictions denied

Facility Representative Signature: _____
_____ Check if **no** restrictions requested

(To be completed by facility Privacy Officer only if resident's acknowledgment not obtained)

Good faith efforts were made to obtain the resident/resident's personal representative written acknowledgment that the resident /representative received DCRNC's Notice of Privacy Practices as follows:

The reason the resident's acknowledgement was not obtained is as follows:

Documented by: _____
Print Name Signature

Title Date Date