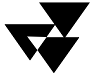

Exeter Health Resources
Affiliated Covered Entity
(EHR ACE)

Includes: Exeter Hospital, Core Physicians, and
Rockingham Visiting Nurse Association and Hospice

PATIENT NAME: ______________________________DATE OF BIRTH: __________________

ACKNOWLEDGEMENT OF BEING INFORMED OF AND BEING OFFERED A COPY OF EHR ACE's NOTICE OF PRIVACY PRACTICES AND, IF APPLICABLE, EXETER HOSPITAL'S PATIENTS' BILL OF RIGHTS

□ I understand my rights as a patient and have been offered a copy of EHR ACE's "Notice of Privacy Practices" (Form #507) and, if applicable, Exeter Hospital's "Patients' Bill of Rights" (Form# 001).

CHOOSE TO OPT IN OR OPT OUT OF THE NEW HAMPSHIRE IMMUNIZATION/VACCINATION REGISTRY

If completing for self:

□ I choose to participate in the New Hampshire immunization/vaccination registry.
□ I choose not to participate in the New Hampshire immunization/vaccination registry.

If completing for child or ward:

□ I choose to have my child or ward participate in the New Hampshire immunization/vaccination registry.
□ I choose to have my child or ward not participate in the New Hampshire immunization/vaccination registry.

I understand that the above decision will not prevent me and/or the identified child or ward from receiving any immunization/vaccination.

I also understand that I may reverse my decision at any time by completing a reverse previous decision form provided by my current health care provider.

____________________	________________________	____________________________________
Date and Time	Printed Name	Signature (***Check One***)

☐ Patient
☐ Parent
☐ Legal Guardian
☐ Designated Surrogate
☐ Personal Representative/Agent

1124