

**Department of State Health Services
Notice of Privacy Practices**

ACKNOWLEDGEMENT OF REVIEW

Date: _____

I have reviewed the Department of State Health Services Notice of Privacy Practices (version effective July 20, 2015), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

Patient Name (Print)

Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

Personal Representative (Print)

Personal Representative Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please be specific):

Employee Signature

Date