Southern Seven Health Department
Acknowledgment of Notice of Privacy Practices

My signature below indicates that I have been given an opportunity to read the “Joint Notice of Privacy Practices” for the Southern Seven Health Department and to have any questions answered before signing.

_______________________________  _______________________
Signed                                      Date

Print Name: ________________________________

If signed by someone other than the patient, please indicate relationship to patient:
☐ Parent or Guardian of minor
☐ Power of Attorney for Health Care
☐ Guardian or conservator with power to make health care decisions for the patient
☐ Beneficiary or personal representative of deceased patient

________________________________________________________________________________________________________________________________________________________________________

FOR OFFICE USE ONLY:

I attempted to obtain an Acknowledgment of the Receipt of the Notice of Privacy Practices on behalf of Southern Seven Health Department. I was unable to obtain the Acknowledgment because:

☐ Client refuses to sign
☐ Other (specify): ___________________________________________________________

_______________________________  _______________________
(Employee Signature)                         (Date)

(Staff: Place Acknowledgment in patient’s medical record.)

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