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NORTH CENTRAL HEALTH DISTRICT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name of Patient: _____

I acknowledge that I received a copy of the Notice of Privacy Practices for the North Central Health District, which sets forth the ways in which my personal health information may be used or disclosed by North Central Health District or the county health department and outlines my rights with respect to such information.

Patient's signature (or personal representative)

Date

If signed by someone other than the patient, please state relationship to patient:

This form will be retained in your medical record.

NCHD-EC-549B — Acknowledgement [Revision #1]