mha Mental Health Association of Orange County
Since 1985

NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the MHA *Notice of Privacy Practices*. Our *Notice of Privacy Practices* provides information about how we may use and disclose your medical information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If you have any questions about our *Notice of Privacy Practices*, please contact the MHA Privacy Officer at (714) 547-7559.

I acknowledge receipt of the MHA *Notice of Privacy Practices.*
Language Received:

- ❑ English
- ❑ Spanish
- ❑ Arabic
- ❑ Farsi
- ❑ Vietnamese
- ❑ Korean

Signature: _____Date: _____
(patient/parent/conservator/guardian)

Print Name: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if signature is not obtained. Please check the box that best applies.

- ❑ -Patient/Client has already received NPP at another County facility.
- ❑ -Patient/Client to receive anonymous testing; wishes to remain anonymous.
- ❑ -Please describe the good faith efforts made to obtain the patient's/client's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____

_____

Signature: _____Date: _____

(Mental Health Association Staff)

Print Name: _____