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| Bwcologo3NOTICE OF PRIVACY PRACTICES | |
| Acknowledgement of Receipt | |
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| ACKNOWLEDGEMENT OF RECEIPT | |
| By signing this form, you acknowledge receipt of the Orange County *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 we change our notice, you may obtain a copy of the revised notice by logging onto <http://ochealthinfo.com/about/admin/hipaa/npp> or by contacting the County Privacy Officer at (714) 834-4082.  If you have any questions about our *Notice of Privacy Practices,* please contact the County Privacy Officer at (714) 834-4082. | |
|  | |
| I acknowledge receipt of the Orange County *Notice of Privacy Practices*.  Print Name: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Patient/Parent/Conservator/Guardian) | |
| **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 below: |
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| Print Name: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (County Clinic/Office Staff) | |