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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. |
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| 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) |