



NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

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: |

Print Name: _____ Date: _____

Signature: _____
(County Clinic/Office Staff)