# NIAGARA COUNTY DEPARTMENT OF HEALTH

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**Child Name** _____ **DOB** _____

**Agency** **Niagara County Department of Health**

I have been offered a copy of Niagara County Department of Health's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Niagara County Department of Health has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer or by visiting the Niagara County Department of Health's web site at http://www.niagaracounty.com/health/Services/Nursing-Division/Notice-of-Privacy-Practices-HIPAA.

**My signature below acknowledges that I have been offered a copy of the Notice of Privacy Practices.**

_____ _____

**Patient or Personal Representative Signature** **Date**

_____

**Printed Name**

_____

**Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)**

**For Agency Use Only: Complete this section if you are unable to obtain a signature.**

1. If the patient or personal representative is unable or unwilling to sign this Acknowledgement, or the Acknowledgement is not signed for any other reason, state the reason:

_____

_____

Our efforts to obtain signature included requesting that the patient sign this acknowledgment at the time we provided him/her with a copy of the Niagara County Department of Health's Notice of Privacy Practices. Despite our good faith effort, the patient failed or refused to sign the above acknowledgment.

**Completed by** _____ **Date** _____

**Printed Name** _____

***File original in patient record***