NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

Client or Subscriber Name: ________________________________

(Please print client or subscriber name)

I, __________________________________________, (Print name of client, subscriber, conservator, parent or legal guardian signing below)

acknowledge receipt of the Notice of Privacy Practices that describes how my medical/health information may be used and disclosed by the County of Marin and how I can get access to my medical/health information.

______________________________________________
(Name of facility, provider or program)

Signed: __________________________________________ Date: _________________

If not signed by client, indicate relationship: ________________________________

Note: Parents must have legal custody. Legal guardians and conservators must show proof of authority.

______________________________________________
This Section to be filled out by a County of Marin Representative

Client did receive the Notice of Privacy Practices (print or audio tape), but did not sign this form because:
☐ Client left the office before the Acknowledgment form could be signed.
☐ Client refused to sign the Acknowledgment form.
☐ Client cannot sign the Acknowledgment form because: ________________________________

Client did not receive the Notice of Privacy Practices (print or audio tape format) because:
☐ Client required emergency treatment.
☐ Client declined to accept a print copy of the Notice and declined to sign this Acknowledgment form.
☐ Client refused to listen to an audio tape version of the Notice and declined to sign this Acknowledgment form.
☐ Other: __________________________________________

NAME OF COUNTY OF MARIN REPRESENTATIVE (PRINT):

SIGNATURE OF COUNTY OF MARIN REPRESENTATIVE: ____________________________ DATE (MONTH/DAY/YEAR): ____________________________