

**Midland County
Department of Public Health**

**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT**

Date: _____

I acknowledge that I was provided with a copy of the Midland County Department of Public Health Notice of Privacy Practices.

Patient Name (Print)

Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

Personal Representative (Print)

Personal Representative's Signature

Relationship

For Midland County Department of Public Health use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Midland County Department of Public Health Notice of Privacy Practices Acknowledgement, but was unable for the following reason:

Employee name

Date

This form should be placed in the patient's medical record

Effective June 1, 2014