CLARK COUNTY HEALTH DEPARTMENT

Acknowledgment of Notice of Privacy Practices

My signature below indicates that I have been given an opportunity to read the Notice Of Privacy Practices for the Clark County Health Department, and to have any questions answered before signing.

Signed: _____ Date: _____

Print Name: _____

If signed by someone other than the patient, please indicate relationship to patient:

[ ] Parent or guardian of minor patient

[ ] Guardian or conservator of an incompetent patient

[ ] Beneficiary or personal representative of deceased patient

FOR OFFICE USE ONLY:

Employee Signature: _____ Date_____

If patient or patient's representative refuses to sign this Acknowledgment:

[ ] Efforts to Obtain: _____

[ ] Reason patient refused to sign: _____

Date of Expiration (3 Years): _____