



**CONSENT and ACKNOWLEDGMENT  
Receipt of Joint Notice of Privacy Practices**

I, \_\_\_\_\_ do hereby consent to allow the health  
(Print Name of Client)

department and its designated employees and contractors to perform a medical evaluation and treat conditions found therein.

I understand the nature and consequences of any procedures to be performed will be explained to me.

I understand that the health department is already authorized to use the information gained during treatment to bill me, any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

I also hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from the health department dated April 14, 2003.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

**Check if any of the following apply:**

- Parent or Guardian of minor
- Power of Attorney for Health Care
- Guardian with power to make health care decisions
- Health Care Surrogate
- Mental Health Treatment Preference Declaration Agent

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**FOR STAFF USE ONLY:**

I attempted to obtain an acknowledgement of the Receipt of the Notice of Privacy Practices on behalf of the HD. The HD was unable to obtain the Acknowledgement because:

- Client refuses to sign                       Other (specify) \_\_\_\_\_

\_\_\_\_\_ Staff Member's initials                      \_\_\_\_\_ Date

(Staff: Place Acknowledgement in client's medical record)

**"This Institution is an equal opportunity provider."**