Clark County Public Health Department

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http://www.clarkhd.org

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): __________________