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): ___________________