Los Angeles County Health Agency

ACKNOWLEDGEMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

Effective Date: May 30, 2017

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of the Los Angeles County (LAC-Health Agency) Departments of Health Services, Mental Health, and Public Health, collectively referred to as the Health Agency. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully.

I acknowledge receipt of the *Notice of Privacy Practices* of LAC-Health Agency.

Signature:_____Date: _____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Workforce Member: _____ Date: _____

Reasons why the acknowledgement was not obtained:

☐ Patient refused to sign.

☐ Other Reason or Comments:

_____

_____

_____

_____