



## Acknowledgement of Receipt of Notice of Privacy Practices

*Effective: April 14, 2003*

I acknowledge that I have reviewed and been offered a copy of the County of Sonoma's Notice of Privacy Practices.

Name of Patient \_\_\_\_\_  
(please print)

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient
- Other patient representative

**Please Note:** Your refusal to sign this document will not impact your ability to receive health care services.

### For Organizational Use Only:

Date acknowledgement received: \_\_\_\_\_

Patient refused to sign.

If acknowledgment was not received, please document the reason you were unable to obtain:

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Signature: \_\_\_\_\_

Please file with client records.