CONSENT and ACKNOWLEDGMENT
Receipt of Joint Notice of Privacy Practices
For Champaign-Urbana Public Health District

I, (insert name of client) ____ (insert Date of Birth) _________________ do hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from the Champaign-Urbana Public Health District (CUPHD) with an effective date of April 14,2003.

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

______________________________Signed

____
(Print Name If Not Signed By Client)

____
Date

If not signed by client, check any of the following that apply:

[ ] Parent or Guardian of minor
[ ] Health Care Surrogate
[ ] Power of Attorney for Health Care
[ ] Mental Health Treatment Preference Declaration Agent
[ ] Guardian with power to make health care decisions
[ ] Other (specify): ____

____

FOR STAFF USE ONLY:

I attempted to obtain an Acknowledgment of the Receipt of the Notice of Privacy Practices on behalf of CUPHD. CUPHD was unable to obtain the Acknowledgment because:

[ ] Client refuses to sign [ ] Other (specify):_________________________

____________________ (Staff member's initials) _________________________ (Date)

(Staff: Place Acknowledgment in patient's medical record.) 09/05 r03/07