MID-COLUMBIA OUTPATIENT CLINICS

The Dalles, OR 97058

PRIVACY NOTICE ACKNOWLEDGEMENT

*Name: _____DOB _____ Medical Record Number: _____

*Address: _____

Telephone: _____ Social Security Number: _____

Individuals' Acknowledgement:

I acknowledge that I received the Privacy Practices Notice of **MID-COLUMBIA OUTPATIENT CLINICS** and its' covered entities**.**

*Signature: _____ *Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

* Required Fields

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Employee Use Only:

Good faith effort to obtain acknowledgement (complete only if you fail to get individual's signed acknowledgement).

☐ Individual refused or was unable to sign an acknowledgement that the individual received our Privacy Practices Notice.

☐ Individual received our Privacy Practices Notice in connection to an emergency treatment situation.

I attest that the above information is correct.

Employee Signature: _____ Date: _____

Print name: _____ Title: _____

Include completed form in the individual's records.
Send copy to the Privacy Official