**WAUKESHA COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES REGARDING HEALTH INFORMATION**

Client Name (Please Print): _____

Client's Date of Birth: _____

Date of Admission or Service: _____

The privacy of your protected health and/or confidential information is important to us. By signing this form, you acknowledge that Waukesha County Department of Health and Human Services (WCDHHS) has provided you with a copy of its most current Notice of Privacy Practices Regarding Health Information, which explains how your health information and/or confidential information will be handled in various situations. All clients receiving services will be asked to sign this form and it will be included in your healthcare record.

If your first date of service with WCDHHS was due to an emergency, we must attempt to provide you with the most current Notice of Privacy Practices Regarding Health Information and obtain your signature acknowledging receipt as soon as possible after the emergency.

By my signature below, I acknowledge I have been offered or have received a copy of the Waukesha County Department of Health and Human Services Notice of Privacy Practices Regarding Health Information, and I have been provided with the opportunity to discuss my concerns and questions.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian/Personal Representative Signature Date

_____
If not client, please describe relationship

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**If this Acknowledgement has not been signed by the client or the client's parent, guardian, or personal representative (above), a WCDHHS workforce member should complete this section:**

1. Was the client provided a copy of the Notice of Privacy Practices regarding Health Information?

   ☐ Yes ☐ No

2. Please explain why the client did not sign this Acknowledgment and explain the efforts made by WCDHHS in attempting to obtain the client's signature:

   _____

   _____

   _____ _____
   Signature of Workforce Member Date