

**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 has given you 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.

You may obtain a copy of the current version of our Notice of Privacy Practices at our website, www.waukeshacounty.gov/HealthAndHumanServices/MedicalRecords/.

If your first date of service with Waukesha County Department of Health and Human Services was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

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

Client Signature

Date

Parent/Guardian/Personal Representative Signature

Date

If not client, please describe relationship

Waukesha County Department of Health and Human Services staff should complete if Acknowledgement Form is not signed:

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

[] Yes [] No

2. Please explain why the client did not sign this acknowledgment form and explain Waukesha County Department of Health and Human Services' efforts in trying to obtain the client's signature: _____

Employee's Signature

Date