# Morrow County Health District

Notice of Privacy Practice Acknowledgement

## Our Legal Duty

We understand that health information about you is personal. We are committed to protecting your health information. We are required by federal and state laws to keep your health information protected and to tell you about how we may share it. We must also tell you about our legal duties and your rights concerning your health information. Please read the Morrow County Health District's Notice of Privacy Practices. You may request a copy for your personal records.

**Patient's Name:** _____ **Patient's Birthdate:** _____

**Person Completing the Form (if different than patient):**_____

## Acknowledgment of Receipt

I have received a copy of the Morrow County Health District's Privacy Practice and my questions have been answered.

**Initial:**_____

## Communication Preferences

I grant permission for the Morrow County Health District to communicate with me in the following manner (check all that apply):

_____Cell Phone:_____

_____OK to send text messages (for appointment reminders)

_____OK to leave a message with detailed information

_____Home phone:_____

_____OK to leave a message with detailed information

_____Mail-Address: _____

_____Work:_____

_____OK to leave a message with detailed information

Please list below individuals that you grant the Morrow County Health District to release your Protected Health Information to:

1. Name_____ DOB_____ Relation_____
2. Name_____ DOB_____ Relation_____
3. Name_____ DOB_____ Relation_____
4. Name_____ DOB_____ Relation_____

**Signature (Patient or Legal Guardian):** _____

**Date:** _____ *(valid for 2 years)*

**Witness Signature:** _____