Health District
OF NORTHERN LARIMER COUNTY

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Name of Client or Client Representative (Please Print) _____ Date of Birth _____

I hereby acknowledge that I received the Health District of Northern Larimer County's Notice of Privacy Practices.

Signature of Client or Client Representative _____ Date (Signature valid for lifetime) _____

(For use when acknowledgement cannot be obtained from the client.)

The client presented to the Health District of Northern Larimer County on _____ (Date) and was provided with a copy of the Health District's Notice of Privacy Practices. A good faith effort was made to obtain from the client a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Client refused to sign.
- ☐ Client was unable to sign or initial because _____
- ☐ The client had a medical emergency, and an attempt to obtain the acknowledgement will be made at the next available opportunity.
- ☐ Other reason (describe below):

_____

_____

Signature of Employee _____ Date _____

[Note: Providers are required to make good faith efforts to obtain acknowledgement that each client has received their Notice of Privacy Practices. Should the individual refuse to acknowledge receipt of provider's Notice of Privacy Practices, the provider should document the "Good Faith Efforts" taken to obtain such acknowledgement. The regulation does not specify how those "Good Faith Efforts" should be documented.]