NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

I understand that the *Notice of Privacy Practices* provides information about how Orange County may use and disclose your medical information and how I may access and exercise my rights regarding my medical information.

Unless required by law or specified in an information blocking exception, OC Health Care Agency does not engage in practices that interfere with the access, exchange, or use of your electronic health information.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by logging onto http://ochealthinfo.com/about/admin/hipaa/npp or by contacting the Office of Compliance at (714) 568-5614 or County Privacy Officer at (714) 834-4082.

If you have any questions about our *Notice of Privacy Practices,* please contact the Office of Compliance at (714) 568-5614 or County Privacy Officer at (714) 834-4082.

I acknowledge receipt of the Orange County *Notice of Privacy Practices*.

Client Name: _____ Date: _____

Signature: _____
(Client/Parent/Conservator/Guardian)

If you are not the client but signing on behalf of a client, complete the following:

Name of Client's Personal Representative: _____

Relationship to Client: _____

Health Information Exchange OPT-IN (unless disclosure is required by law)

A Health Information Exchange (HIE) allows us to share your information electronically with other health care providers outside of our facility who are involved in your care. If you would like to opt-in to this process, we will share your information with your participating providers as necessary for treatment. If you would like to opt-out of this process at any time after you have elected to opt in, please contact your provider.

Client/client representative initials are required in the box below if electing to opt-in.

	Patient/Client has elected to **OPT-IN**.

If the client has elected to opt-in to the HIE, the Authorization to Use and Disclose (ATD) is required to be completed to share PHI in the HIE.

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if signature is not obtained. Please check the box that best applies.

☐	Declined to sign
☐	Other reason. Please describe the good faith efforts made to obtain the patient's/client's acknowledgement, and the reasons why the acknowledgement was not obtained below:

Print Name: _____ Date: _____

Signature: _____
(County Clinic/Office Staff)