

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
PORTSMOUTH CITY HEALTH DEPARTMENT**

Patient Name: _____
Medical Record #: _____
Date of Appointment: _____

My signature on this form acknowledges that I have received a copy of Portsmouth City Health Departments Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by PCHD and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

Patient's Signature

Date

Signature of Patient's Representative
if patient is unable to sign

Date

**TO BE COMPLETED BY HEALTH DEPARTMENT EMPLOYEE IF FORM IS NOT
SIGNED**

1. Was the patient provided with a copy of the agency's Notice of Privacy Practices?
 Yes No

2. Briefly describe efforts made to obtain the patient's acknowledgment of receipt of the Notice and explain why the patient was not able or willing to sign this form: _____

Signature of Health Department Employee

Date