Indian Health Council
50100 Golsh Rd
Valley Center CA 92082
760-749-1410

Empowering Native Wellness

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

By signing this form, you acknowledge receipt of Indian Health Council's current "Notice of Privacy Practices." The "Notice" describes how we may use and disclose your protected health information and informs you of your rights with respect to your protected health information. We encourage you to read it in full.

I understand that I may request a copy of the "Notice of Privacy Practices" at any time. I understand that the Notice may also be viewed at: www.indianhealth.com.

I understand that the "Notice of Privacy Practices" is subject to change. I understand that Indian Health Council will inform me of such changes.

_____ _____

Signature of Patient or Legal Representative Date

If signed by other than patient, please indicate relationship: _____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Indian Health Council, Inc. has made good faith efforts to obtain your signature. This section will only be completed if no signature is obtained.

Reasons why the Acknowledgement was not signed:

Patient refused to sign this Acknowledgement even though the patient was asked to do so and was given the Notice of Privacy Practices.

Other: _____

_____ _____

IHC Employee Name Date

_____

Signature