NAME: _____ **CLIENT ID:** _____

Health Department

Notice of Privacy Practices Acknowledgement Form

I have received a copy of Macomb County Health Department's Notice of Privacy Practices. I understand that my acknowledgement of the Notice is evidenced by my signature on this document.

The Department is required to abide by the terms of this privacy notice. The Department may change the terms of its notice at any time. The new notice will be effective for all protected health information that it maintains at that time. Upon my request, the Department will provide me with the revised notice of privacy practices.

Dated:_____ **_____**

Signature of Client or Personal Representative

_____

Print Name of Client or Personal Representative

☐ **Received Notice of Health Information Practices, refused written acknowledgement**