ACKNOWLEDGEMENT OF RECEIPT OF IHS NOTICE OF PRIVACY PRACTICES

I HEREBY ACKNOWLEDGE RECEIPT OF THE INDIAN HEALTH SERVICE (IHS) NOTICE OF PRIVACY PRACTICES AT:

FORT THOMPSON INDIAN HEALTH SERVICES
PO BOX 200
FORT THOMPSON, South Dakota 57339

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Date
(State Relationship to patient or witness (if signature is by thumb print or mark)

_____ _____
Signature and Title of IHS Employee Date

FOR PATIENTS UNABLE TO ACKNOWLEDGE RECEIPT

I HEREBY CERTIFY THAT THE PATIENT WAS UNABLE TO ACKNOWLEDGE RECEIPT OF THE IHS NOTICE OF PRIVACY PRACTICES
BECAUSE_____

_____ _____
Signature and Title of IHS Employee Date