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

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Signature of Patient Date

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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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature and Title of IHS Employee Date