

## ACKNOWLEDGMENT

*By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the program and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information.*

Service Recipient or Personal Representative	Printed name:	
	Signature:	Date:
	If signed by a <b>Personal Representative</b> , please describe authority:	

Privacy Notice effective date: 12/2020