HIPAA FORM #8-A
Acknowledgement from Client on Receipt of BCPH's Notice of Privacy Practices

Boulder County Public Health (BCPH) is committed to the protection of your privacy and to enforcement of your rights under the Health Insurance Portability and Accountability Act (HIPAA). By signing this form, you acknowledge you have been provided a copy of *BCPH HIPAA Form #8, Notice of Privacy Practices*, which explains how we may use and disclose (share) your protected health information (PHI), as provided by HIPAA. We encourage you to read the Notice in its entirety.

Acknowledgement of Receipt (please print)

This is to acknowledge that the following has received a copy of the Boulder County Public Health Notice of Privacy Practices.

Client Information (PLEASE PRINT):

Name of Client:	Date of Birth:
Address:	
City/State/Zip:	
Daytime Phone:	Evening Phone:

Client Signature:_____ Date:_____

If you are NOT the client listed above, please complete the following (PLEASE PRINT):

What is your relationship to the client?

- ☐ Parent or guardian of the client, who is a minor
- ☐ Guardian or conservator of the client, who is incompetent
- ☐ Beneficiary or personal representative of the client, who is deceased
- ☐ Other – please specify:_____

Your Name:	Date of Birth:
Address:	
City/State/Zip:	E-Mail:
Daytime Phone:	Evening Phone:

Signature of Client Representative:_____ Date:_____

Good Faith Effort to Obtain Acknowledgement (complete when client/personal representative declines to sign this form)

Describe the good faith efforts that BCPH made to obtain the client/personal representative's acknowledgement of receipt of BCPH's HIPAA Notice of Privacy Practices and the reason(s) why the individual declined to sign this form:

Signature of BCPH Representative:_____ Date:_____

Printed Name:_____ Title:_____

Last Revised: February 10, 2015