

**ACKNOWLEDGEMENT OF  
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A  
COPY OF THE FRANKLIN COUNTY HEALTH  
DEPARTMENT'S NOTICE OF PRIVACY PRACTICES  
WITH THE EFFECTIVE DATE OF APRIL 14<sup>TH</sup>, 2003**

\_\_\_\_\_  
Signature of Patient/Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Name of Minor Child