Sioux Rivers
REGIONAL MENTAL HEALTH & DISABILITIES SERVICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE FOR HEALTH CARE PROVIDERS

I, _____, do hereby acknowledge receipt of a copy of Sioux Rivers MHDS Region Notice of Privacy Practice.

_____ _____
Signature of Individual: Date:

NOTICE IS RECEIVED BY THE INDIVDIUAL'S PERSONAL REPRESENTATIVE/GUARDIAN

_____ _____
Signature of Personal Representative: Date:

_____
Legal Authority of Personal Representative