

**NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt Form**

Patient's Acknowledgement of Receipt

The Olathe Health System, Inc. (OHSI), **Notice of Privacy Practices** provides a thorough explanation of how we may use and disclose your protected health information, as well as your rights as a patient.

I, _____ (*print your name*), have received a copy of the Olathe Health System, Inc. Notice of Privacy Practices.

I choose to designate the individuals listed below as my primary contacts. Olathe Medical Services personnel may share information with these primary contacts that is consistent with the Notice of Privacy Practices.

Patient's Name: _____ Patient's DOB _____

Contact Name _____ Contact Name _____

Relationship _____ Relationship _____

Phone: _____ Phone: _____

Signature _____ Date: _____
(*Patient, Parent, Authorized Representative*)

Inability to Obtain Acknowledgement


To be completed by OHSI Representative:

It was not possible to obtain the individual's acknowledgement, due to:

- Emergency Situation
- Patient physically unable to sign
- Patient Refused
- Patient left office prior to obtaining signature
- Other Reasons (explain) _____

Name of Patient _____
Comments _____

Signature of OHSI Representative _____ Date: _____

Olathe Medical Services, Inc. 
***16500 W. Indian Creek Parkway,
Suite 102; Olathe, KS 66062***

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

CC: cd
(02/10) **OMSI No. 149**