NOTICE OF PRIVACY PRACTICES:

Acknowledgement of Receipt Form

Patient's Acknowledgement of Receipt

I,	Patient	's Name:	Patient's DOB			
Signature	I,		(print your name), h	ave recei	ived a copy of th	e Olathe Health System,
(if Parent signs for a minor child, this designation expires on the child's 18 th birthday) Olathe Health Physicians provides this form for you to designate certain individuals with whom we may share certain information about your treatment. This is voluntary. You do not have to designate anyone. I choose to designate the individuals listed below as my primary contacts. I have checked the boxes of the types of information which I consent to Olathe Health Physicians sharing with the contact. This designation does not apply to information of a sexual health matters (including STDs and pregnancy), issues of substance abuse, or Mental Health treatment (any treatment/visit as the result of a mental health treatment, I must complete an Authorization for Release of Protected Health Information (OHP 581) if I wish another person pick up a copy of my medical records. Contact Name	Inc. Not	tice of Privacy Practices.				, , , , , , , , , , , , , , , , , , ,
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Inability to Obtain Acknowledgement