NOTICE OF PRIVACY PRACTICES:
Acknowledgement of Receipt Form

Patient's Acknowledgement of Receipt

The Olathe Health, ***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.

Patient's Name: _____ Patient's DOB _____

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

Signature _____ Date:_____
(Patient, Parent, Authorized Representative)
(if Parent signs for a minor child, this designation expires on the child's 18th 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 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 diagnosis). If I wish to share information of a sexual health matter or regarding mental health treatment, I must complete an Authorization for Release of Protected Health Information (OHP 581). I also must complete a Release of Protected Health Information form (OHP 581) if I wish another person to pick up a copy of my medical records.

Contact Name _____ Relationship _____

Contact Name Phone: _____

- ☐ Any and all Information
- ☐ Appointment Reminders
- ☐ Billing and payment Information (includes amount due, status)
- ☐ General Condition (non-diagnosis specific information)
- ☐ Future Appointment Dates
- ☐ Lab Results
- ☐ Prescription Information
- ☐ Radiology Results
- ☐ Visit Information (what was found during Doctor Visit)

Contact Name _____ Relationship _____

Contact Name Phone: _____

- ☐ Any and all Information
- ☐ Appointment Reminders
- ☐ Billing and payment Information (includes amount due, status)
- ☐ General Condition (non-diagnosis specific information)
- ☐ Future Appointment Dates
- ☐ Lab Results
- ☐ Prescription Information
- ☐ Radiology Results
- ☐ Visit Information (what was found during Doctor Visit)

Signature _____ Date:_____
(Patient, Parent, Authorized Representative)
(if Parent signs for a minor child, this designation expires on the child's 18th birthday)

Olathe Health Physicians
13045 S Mur-Len
Olathe, KS 66062

Acknowledgement of Receipt of Notice of Privacy Practices and Voluntary Contact Form

Inability to Obtain Acknowledgement

To be completed by OHP 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 OHP Representative_____ Date:_____