

City of Lincoln
Lincoln-Lancaster County Health Department
Notice of Privacy Acknowledgement

I acknowledge that I have received a copy of the City of Lincoln, Lincoln-Lancaster County Health Department's "Notice of Privacy" on _____.

Date

The Notice of Privacy was last updated on:

Name of patient: (please print) _____

Signature: _____

___ Signing for myself

___ Signing as parent or guardian of patient

Name of interpreter if needed: _____ Interpreter signature: _____
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Please note:

- ❖ Federal HIPAA law does not require you to sign this acknowledgment
- ❖ Signing the acknowledgement does not mean that you have agreed to any special uses or disclosures of your health information
- ❖ Refusal to sign the acknowledgement does not affect the Health Department from using and disclosing your health information as the HIPAA rule permits.
- ❖ You are not required to sign in order to receive our services
- ❖ The Health Department is required to keep a record, that they failed to obtain your acknowledgement