Clermont County Public Health

Prevent. Promote. Protect.

PLEASE RETURN SIGNED FORM(S)

Acknowledgement of
Receipt of Notice of Privacy Practices

I, _________________________________ acknowledge that I have received the Notice of Privacy Practices issued by Clermont County Public Health. I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement. This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided, if requested.

I, _________________________________ authorize the Clermont County Health Department to discuss my protected health information with the following person(s):

(Please print):

Spouse_________________________________ Parent_________________________________

Children_______________________________ Other__________________________________

Name of patient (please print): ____
Date of birth of patient: ___ /____ /_______
Name of legal guardian, if applicable (please print):___________________________________
Signature of patient/legal guardian: ____
Signature date: ___ /____ /_______

If you have any questions about this Notice please contact:
Privacy Officer
Clermont County Public Health
2400 Clermont Center Drive, Suite 200
Batavia, Ohio 45103
(513)735-8400

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