



County of Santa Cruz Health Services Agency

Patient Acknowledgement of Receipt of Notice of Privacy Practices

The County of Santa Cruz Health Services Agency believes that your personal privacy and the privacy of your family is an important matter. In providing treatment to you, or a member of your family it may be necessary for us to collect protected health information of a private and/or personal nature. We take seriously our obligation to protect disclosure of this information without your consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you or your family members for treatment, payment or health care operations. It also describes other situations where we may disclose or be required to disclose protected health information about you. You have the right to review our Privacy Practices before signing this acknowledgment form. As provided in our notice, the terms of our notice may change.

[Click here to review the Notice of Privacy Practices](#)

If we change our notice, click here to view the most current copy. you may obtain a revised copy by: 1) visiting our [client information website](#); or 2) calling the office and requesting that a revised copy be sent to you in the mail; or 3) asking for one at the time of your next appointment

By signing this form, you acknowledge receipt of the Santa Cruz County Notice of Privacy Practices.

Client Name: _____

Client Signature _____ **Date** _____

Parent/Legal Guardian Signature _____ **Date** _____