ONTARIO COUNTY MENTAL HEALTH CENTER

Receipt of Ontario County Notice of Privacy Practice

By signing this form, I hereby acknowledge that I have received and reviewed a copy of the Ontario County Notice of Privacy Practice.

Is patient a minor? ☐ Yes ☐ No Under age 12? Yes No Is adult patient legally reponsible for their own care? Yes No

Patient's Signature
(required for patients 12 years and older)

Personal Representative's Signature
(required for minors under 12, or adults with a legally designated person who can act/sign on his/her behalf)

Patient's Name (Printed)

Personal Representative's Name (Printed)

Description of Personal Representative's Authority to Act (or sign) for the Patient (Required if Personal Representative signs this authorization form.)

Date

***For Office Use Only*:**

Reviewed By:

Staff Signature

Staff Person Name

Staff Person Title

Date Reviewed

Revised 04.21.20