Student Health Services
The Ohio State University
1875 Millikin Road
Columbus, Ohio 43210

Last Name	First Name	Middle Initial
MRN		

(Place patient label here)

I acknowledge that I was provided my personal copy of Student Health Services' Notice of Privacy Practices. This notice describes my patient rights and how my health information is used and shared.

I understand that Student Health Services has the right to change this notice at any time and that I may obtain a current copy upon request or by visiting www.shs.osu.edu.

_____ _____

Printed Name of Patient Date of Birth

_____ _____ _____

Signature of Patient or Legal Representative Relationship (if **NOT** the patient) Date

FOR OFFICE USE ONLY

SHS has made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason(s):

☐ Patient/Representative refused to sign
☐ Communication barriers prohibited obtaining an acknowledgement
☐ An emergency situation prevented us from obtaining an acknowledgement
☐ Other _____

Staff Signature/Title_____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT