

2515 STATE STREET
CHESTER, IL 62233-1149
PHONE: (618) 826-5007
STREET
FAX: (618) 826-5223



Clinic Site:
211 NORTH HASLE STREET
612 EAST MORTON

SPARTA, IL 62286

PHONE: (618) 443-2995

FAX: (618) 443-6960

**CONSENT and ACKNOWLEDGMENT
Receipt of Joint Notice of Privacy Practices**

I, _____ do hereby consent to allow the Randolph
(print name of client)

County Health Department and its designated employees and contractors to assess, evaluate, provide care, bill for services and/or refer me. I understand the nature and consequences of any procedures to be performed will be explained to me.

I understand that the health department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

I also hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from the health department dated July 1, 2009.

Signed

Date

Check if any of the following apply:

- | | |
|--|---|
| <input type="checkbox"/> Parent or Guardian of minor | <input type="checkbox"/> Health Care Surrogate |
| <input type="checkbox"/> Power of Attorney for Health Care | <input type="checkbox"/> Mental Health Treatment Preference Declaration Agent |
| <input type="checkbox"/> Guardian with power to make health care decisions | |

FOR STAFF USE ONLY:

I attempted to obtain an Acknowledgment of the Receipt of the Notice of Privacy Practices on behalf of the HD.

The HD was unable to obtain the Acknowledgment because:

- Client refuses to sign Other (specify): _____

(Staff member's initials)

(Date)

(Staff: Place Acknowledgment in patient's medical record.)



Public Health
Prevent. Promote. Protect.