State of Alaska
Department of Health and Social Services

ACKNOWLEDGEMENT OF RECEIPT OF DHSS NOTICE OF PRIVACY PRACTICES

_____ _____
Printed Name of Client/Patient | Client/Patient Date of Birth or Other Identification

Please indicate that you have received a copy of the DHSS Notice of Privacy Practices by checking below and signing your name*.

☐ I have received a copy of the DHSS Notice of Privacy Practices.

_____ _____
Signature of Client/Patient or Personal Representative* (Or Witness if signature is by mark) | Date Acknowledgement Signed

_____ _____
Printed Name of Personal Representative or Witness | Description of Personal Representative's Authority

* Personal Representative signature required if client/patient is a minor or adult who is unable to sign this form.

DHSS STAFF ONLY: This portion to be completed by DHSS staff ONLY if unable to obtain client/patient acknowledgement signature above OR if acknowledgement was translated for a client. Indicate that the acknowledgement was translated or the reason acknowledgement was not obtained by checking the appropriate box, entering other information (if necessary) and print staff name and translator name (if necessary).

☐ Acknowledgement was translated for Client/Patient by:

_____(Printed Name of Translator).

An attempt was made to obtain acknowledgement for receipt of DHSS Notice of Privacy Practices. Acknowledgement was not obtained because:

☐ Client/Patient declined to sign acknowledgement

☐ Other: (explain) _____

_____ _____
Printed Name of DHSS Staff | Date