

**Confirmation of Receipt of HIPAA Policy and Procedure regarding my**

**Protected Health Information (PHI) and Privacy**

I acknowledge that I have been provided the Dakota County Health Department’s HIPAA Policy regarding Privacy Policies with Protected Health Information (PHI).

I acknowledge that copies of this policy are available to be taken with me are visible on the Dakota County Health Department’s bulletin information board.

Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employee who Provided Policy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Information Provided: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_