ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF THE OSF HEALTHCARE SINGLE AFFILIATED COVERED ENTITY

I acknowledge that I have received or been offered the Notice of Privacy Practices of the OSF HealthCare Single Affiliated Covered Entity bearing the Effective Date of September 23, 2013. I understand that the Notice describes the uses and disclosures of my protected health information by the Covered Entities which collectively constitute the OSF HealthCare Single Affiliated Covered Entity and informs me of my rights with respect to my protected health information.

_____

Name of Patient

_____ _____

Medical Record Number **Date of Birth**

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____

Date

If Personal Representative, indicate relationship:

_____

Declinations

_____ The Individual declined to accept a copy of the Notice of Privacy Practices.

_____ The Individual received a copy of the Notice of Privacy Practices but declined to sign an Acknowledgment of Receipt.

_____ _____

Signature of OSF HealthCare Representative Name of OSF HealthCare Representative