UNIVERSITY OF NORTH DAKOTA
Student Health Services
McCannel Hall
P.O. Box 9038
Grand Forks, North Dakota 58202
701.777.4500 Fax: 701.777.4835

ACKNOWLEDGEMENT OF NOTICE OF PATIENT PRIVACY PRACTICES

Effective April 14, 2003

I acknowledge that I have received a written copy of the University Of North Dakota Student Health Services Notice Of Patient Privacy Practices. I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be part of my record until such time as I may choose to revoke this acknowledgement. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

_____ _____

Date Signature of Patient or Authorized Agent

TO BE COMPLETED BY STUDENT HEALTH STAFF IF NO ACKNOWLEDGEMENT CAN BE OBTAINED

Good faith efforts were made to obtain acknowledgement from the patient or patient's authorized agent. The good faith efforts made, and the reason acknowledgement could not be obtained, were:

☐ Patient (or authorized agent) refused to sign Notice of Privacy Practices.

☐ Other (please describe):_____

_____ _____

Signature of Student Health Privacy Coordinator Date

Revised 3/03