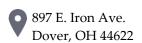


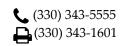


Acknowledgement of Receipt of the Notice of Privacy Practices of the Tuscarawas County Health Department Medical Clinic

Patient Name:	
Date of Birth:	
Address:	Telephone No
Medical Clinic a copy of its Notice of I Practices sets forth my rights relating to and explains how the Tuscarawas Copersonal health information both with may contact the Compliance Officer if I of Privacy Practices or to file a complain	eived from the Tuscarawas County Health Department Privacy Practices. I understand that the Notice of Privacy the use and disclosure of my personal health information ounty Health Department may use and/or disclose my and without my authorization. I further understand that I have any questions regarding the contents of this Notice int about the privacy practices of the Tuscarawas County epartment's Medical Clinic.
	Date

12/05/2022 KS





Signature of Patient or Patient's Representative

