



069397

Acknowledgement of Receipt of Notice of Privacy Practices

I have been made aware of Valley Health System’s **Notice of Privacy Practices**, I received a copy of this document on today’s date, and I have a right to request additional copies in the future. The Valley Health **Notice of Privacy Practice** describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Valley Health System’s health care operations. The Notice also describes my rights and Valley Health System’s responsibilities with respect to my protected health information.

I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Valley Health system’s web site at <http://www.valleyhealthlink.com>. I may request that a copy be mailed to me by calling **866-414-4576**.

Valley Health System reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Valley Health System’s web site listed above to view the most current version.

Signature

Date / Time

Relationship to Patient (if not signed by the patient)

Witness

Date / Time

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

Form#: 9397 Date: 2/14, 6/14
HIPAA Pt Acknow Receipt

Patient Label