CRAWFORD COUNTY HEALTH DEPARTMENT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Crawford County Health Department's Notice of Privacy Practices with the effective date of April 14, 2003.

_____ _____

Signature of Patient/Patient Representative Date

_____

Print Name of Patient/Patient Representative

_____

Relationship to Patient

Original to be maintained in Patient's permanent medical record.