Connected Whole Health
at University of Western States
8000 NE Tillamook Street | Portland, OR 97213 | Suite A
Phone: 503-808-7979 | Fax: 503-808-7988
uwsconnectedhealth.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form represents documentation that Connected Whole Health of Privacy Practices was given to the patient or their personal representative.

By signing this form, you acknowledge receipt of Connected Whole Healths' Notice of Privacy Practices. The notice provides information about how we may use and disclose your protected health information. You are encouraged to review the notice carefully.

I acknowledge receipt of Connected Whole Health Privacy Practices.

Signature: _____ Date: _____
(Patient or personal representative)

If you are signing as a personal representative, please complete the following:

Parent/ Guardian/ Personal representative's name: _____

Relationship to patient: _____

Connected Whole Health Use Only:

☐ Inability to obtain acknowledgement

To be completed only if a signature is not obtained. Describe the efforts made to obtain the individual's acknowledgement and the reasons why the acknowledgement was not obtained.

_____

_____

☐ Notice already given

Location: _____ Date: _____

Signature of Connected Whole Health representative: _____

(Revised 02/08/21)