DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE
790 Governor Carlos Camacho Road, Tamuning, Guam 96913
Telephone: (671)647-5330 / 5440, Facsimile: (671)649-6948

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

As required by Privacy Regulations, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES", revision date __________________.

As required by the Privacy Regulations, ______________________________ from this practice
Name of Staff Member
has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that this practice has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

I wish to file a "Request for Restriction" of my Protected Health Information.
I wish to file a "Request for Alternative Communications" of my Protected Health Information.
I wish to object to the following in the "Notice of Privacy Practices":

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I understand that this office is not required to honor any changes to the "Notice of Privacy Practices".

______________________________	______________________
Consumer or Personal Representative Sign Name	**Date**
______________________________	______________________
Consumer or Personal Representative Print Name	**Relationship to Consumer**

(DMHSA Office Use Only)
Our organization has made a good faith effort to obtain a written Acknowledgement Receipt of the Notice of Privacy Practices provided to the individual named below because he/she:

Refused to Sign   Physically unable to Sign   Other ___________

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Employee Print Name/Title: __________________________________Date:__________

Witness Print Name/Title: ____________________________________Date:__________

Consumers Name: __________________________

DMHSA- HIPAA 001:03/05   **DOB:** ____________**Medical Record #**_________