Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have been provided a copy of this Notice of HIV/AIDS Privacy Practices and have therefore been advised of how HIV-related information about me may be used and disclosed by health care facilities and operations of the State University of New York, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information and genetic information.

___________________________________________
Signature of Client or Personal Representative

____________________________________________
Print Name of Client or Personal Representative

____________________________________________
Date

____________________________________________
Description of Personal Representative’s Authority

____________________________________________
Notice of Privacy Practices Version Number

____________________________________________
Notice of Privacy Practices Date