



**ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES**  
**OF THE OSF HEALTHCARE**  
**SINGLE AFFILIATED COVERED ENTITY**

I acknowledge that I have received or been offered the Notice of Privacy Practices of the OSF HealthCare Single Affiliated Covered Entity bearing the Effective Date of September 23, 2013. I understand that the Notice describes the uses and disclosures of my protected health information by the Covered Entities which collectively constitute the OSF HealthCare Single Affiliated Covered Entity and informs me of my rights with respect to my protected health information.

\_\_\_\_\_  
**Name of Patient**

\_\_\_\_\_  
**Medical Record Number**

\_\_\_\_\_  
**Date of Birth**

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Printed Name of Patient or Personal Representative**

\_\_\_\_\_  
**Date**

**If Personal Representative, indicate relationship:**

\_\_\_\_\_

**Declinations**

\_\_\_\_\_ The Individual declined to accept a copy of the Notice of Privacy Practices.

\_\_\_\_\_ The Individual received a copy of the Notice of Privacy Practices but declined to sign an Acknowledgment of Receipt.

\_\_\_\_\_  
**Signature of OSF HealthCare Representative**

\_\_\_\_\_  
**Name of OSF HealthCare Representative**