Klamath Tribal Health & Wellness Center
330 Chiloquin Blvd, PO Box 490
Chiloquin, OR 97624
(541) 882-1487

| KTHFS Use Only |
| --- |
| |
| Chart Number |

# Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge receipt of Klamath Tribal Health & Family Services Notice of Privacy Practices:

Patient Name: _____
(Please Print)

Signature of Patient: _____ Date_____
Or Patient Representative
Or Witness (if signature is by thumb print or mark)

Print Name of Patient Representative or Witness:_____

State relationship to Patient: _____

Signature and Title of KTH&FS Employee: _____ Date_____

# For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the KTH&FS Notice of Practices because:

_____

_____

_____

Signature and Title of KTH&FS Employee: _____ Date_____