Student Health Services
The Ohio State University
1875 Millikin Road
Columbus, Ohio 43210

Last Name	First Name	Middle Initial
MRN		
	(Place patient label here)	

I acknowledge that I was provided my personal copy of Student Health Services' Notice of Privacy Practices. This notice describes my patient rights and how my health information is used and shared.

I understand that Student Health Services has the right to change this notice at any time and that I may obtain a current copy upon request or by visiting www.shs.osu.edu.

_________________________________ ______________________

Printed Name of Patient Date of Birth

_________________________________ ________________ ___________

Signature of Patient or Legal Representative Relationship (if **NOT** the patient) Date

FOR OFFICE USE ONLY

SHS has made a good faith effort to obtain written acknowledgement of receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained for the following reason(s):

- ☐ Patient/Representative refused to sign
- ☐ Communication barriers prohibited obtaining an acknowledgement
- ☐ An emergency situation prevented us from obtaining an acknowledgement
- ☐ Other ____

Staff Signature/Title____ Date ____________

Rev 8/10

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT