

**BUTLER UNIVERSITY HEALTH SERVICES**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

You have the right to receive a paper copy of the Butler University Health Services ("Health Services") Notice of Privacy Practices. You may request that we give you a copy of this Notice at any time.

I, \_\_\_\_\_, acknowledge that I was given the opportunity to receive a copy of the Health Services Notice of Privacy Practices which describes the uses and disclosures of my protected health information that may be made by the Health Services, and my rights and the Health Services legal duties with respect to my protected health information.

\_\_\_\_\_  
Print Name (Patient/Client)

\_\_\_\_\_  
Student ID

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Print name if you are the personal representative of the patient/client: \_\_\_\_\_

Your relationship, including authority, for status as representative: \_\_\_\_\_

For further information please contact the Director of Butler University Health Services or consult our Notice of Privacy Practices available at: Butler University Health Services

<p><b>FOR HEALTH CENTER USE ONLY:</b></p> <p>Date received: _____</p> <p>Comments: _____</p> <p>_____</p> <p>If not signed, indicate good faith measures to obtain signature: _____</p> <p>Staff Member Signature _____ Date _____</p>
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