Confederated Tribes of Siletz Indians
Siletz Community Health Clinic
Post Office Box 320 • 200 Gwee-Shut RD
Siletz, OR 97380
Telephone: 800-648-0449 • (541)444-1030
Facsimile: (541)444-9695

ACKNOWLEDGEMENT OF RECEIPT OF SCHC NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of Siletz Community Health Clinic (SCHC) Notice of Privacy Practices (NOPP) effective date 12/31/2018. I understand this Acknowledgement is valid for one-year.

Patient

Print name, sign and date. If your signature is by your mark or thumbprint then your Representative or Witness will need to complete the Representative/Witness section.

Patient's Name Printed _____ Date Signed _____

Patient's Signature _____ Mark or Thumb Print _____

Representative/Witness (If applicable)

If Patient has a Representative or is unable to sign the Patient's Representative or Witness completes this section.

Representative/Witness's Name Printed _____ Relationship _____

Representative/Witness's Signature _____ *Date Signed* _____

SCHC Employee

SCHC Employee's Signature and Title _____ *Date Signed* _____

SCHC HEALTH INFORMATION USE ONLY:

Scanned _____ MRN _____ NOPP Expires _____