**NOTICE OF PRIVACY PRACTICES**

**ACKNOWLEDGEMENT COVER SHEET**

**Please have the client or personal representative (on behalf of the client) complete this cover sheet and file it in the client’s case record along with protected health information.**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print client name), hereby acknowledge that I have received a paper copy of the notice of privacy practices (CHFS-300), with an effective date of February 2004. I understand that this notice may be amended at a later date and any amended notice will be posted on the** [**Cabinet’s internet site**](http://chfs.ky.gov/dcbs/dcc/hipaa.htm)**. I acknowledge and agree that if I have questions or concerns regarding amendments to the notice of privacy practices given to me this day I will:**

* **Review the Cabinet’s web site for any amendments to the notice; or**
* **Request a paper copy of the amended notice from any Department for Community Based Services, Division of Protection and Permanency (DPP) Office.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client’s Signature or Signature of Date**

**Personal Representative/Legal Guardian/**

**Parent of Minor**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DPP Workforce Staff Signature Date**

**Note: If the client will not or cannot sign, the DPP workforce staff signs and dates the area below to indicate a good faith effort that failed to obtain written acknowledgment, and files it in the client’s case record.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DPP Workforce Staff Signature Date**