

**PIERCE COUNTY**  
**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**REGARDING HEALTH INFORMATION**

Employee Name: \_\_\_\_\_

Date sent: \_\_\_\_\_

By signing this form, you acknowledge that Pierce County has given you a copy of its Notice of Privacy Practices Regarding Health Information, which explains how your health information will be handled in various situations. **All Employees will be asked to sign this form.**

By my signature below, I acknowledge I have received a copy of the Pierce County Notice of Privacy Practices Regarding Health Information. If you would like to see a copy of the HIPAA Policy/Procedure please contact the Administration Office, 715-273-3531, Ext 6430.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Pierce County Administration should complete if this Acknowledgement form is not signed:**

1. Was the Employee given a copy of the Pierce County Notice of Privacy Practices Regarding Health Information:

( ) Yes ( ) No

2. Please explain why the Employee did not sign this acknowledgment form and explain Pierce County efforts in trying to obtain the Employee's signature: \_\_\_\_\_

\_\_\_\_\_

Administration Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_