# ACKNOWLEDGEMENT OF RECEIPT

*INDIANA UNIVERSITY HEALTH CENTER'S*
*NOTICE OF PRIVACY PRACTICES*

I, _____, do hereby acknowledge that on this date, _____, received a copy of Indiana University Health Center's Notice of Privacy Practices.

By signing below, I am signifying that I have received the Notice of Privacy Practices and its explanation of how Indiana University Health Center will use my personal health information in relation to treatment, payment and health care operations, as well as my rights regarding the management of this information.

_____ _____
*Patient's Signature* *Date*

_____
*Patient's Printed Name*

_____
*Student ID Number or Social Security Number*

*Please return form to:*

*Indiana University Health Center*
*ATTN: Medical Records Department*
*600 North Jordan Avenue*
*Bloomington, IN 47405-3191*