

**ACKNOWLEDGEMENT OF  
RECEIPT OF THE NOTICE OF PRIVACY PRACTICES  
WESTERN MICHIGAN UNIVERSITY**

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (269) 387-3292, on the University's website at [www.wmich.edu](http://www.wmich.edu), our website at [www.wmich.edu/shc](http://www.wmich.edu/shc), or by requesting one at the Sindecuse Health Center.

\_\_\_\_\_  
(Signature\*)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print or Type Name)

\_\_\_\_\_  
(Social Security Number)

**\*As the personal representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.**

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Relationship)

\_\_\_\_\_  
(Print or Type Name)

\_\_\_\_\_  
(Date)

**FOR CLINIC USE ONLY:**

Sindecuse Health Center made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Staff Signature)

\_\_\_\_\_  
(Date)