CONDADO DE LOS ANGELES- DEPARTAMENTO DE SALUD MENTAL

NOTIFICACIÓN DE NORMAS DE CONFIDENCIALIDAD O PRIVACIDAD :

Comprobante de recibo ***Vigente a partir del: 23 de Septiembre, 2013***

COMPROBANTE DE RECIBO

Con la firma de este formulario, usted confirma haber recibido la *Notificación de Normas de Confidencialidad o Privacidad* del Departamento de Salud Mental del Condado de Los Ángeles (LAC-DMH, por sus siglas en inglés). En nuestra *Notificación de Normas de Confidencialidad* se proporciona información sobre la manera en que podremos usar y revelar su información médica protegida. Le invitamos a que la revise cuidadosamente.

Nuestra *Notificación de Normas de Confidencialidad* está sujeta a cambios. Si hacemos cambios a nuestra Notificación, usted podrá obtener una copia de la Notificación revisada si visita nuestro sitio (*http//www.dmh.lacounty.gov*) o si la solicita a nuestro Equipo de Tratamiento.

Confirmo haber recibido la *Notificación de Normas de Confidencialidad* del LAC-DMH.

Firma: _____Fecha: _____

(Cliente/padre o madre/"conservator" o curador/tutor)

FOR STAFF ONLY INABILITY TO OBTAIN CLIENT SIGNATURE
INCAPACIDAD PARA CONSEGUIR EL COMPROBANTE DE RECIBO

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Treatment Team Member: _____ Date: _____

Reasons why the acknowledgement was not obtained:

- q **Client refused to sign (see progress notes for explanation)**
- q **Other Reason or Comments:**

_____

_____

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THIS IS A TWO SIDED BILINGUAL DOCUMENT.

LOS ANGELES COUNTY-DEPARTMENT OF MENTAL HEALTH

NOTICE OF PRIVACY PRACTICES:

Acknowledgement of Receipt

Effective Date: September 23, 2013

TRANSLATION: NO ☐ YES ☐

This Acknowledgement was translated into _____ for the client and /or responsible adult*

_____ _____

PRINT NAME OF TRANSLATOR **DATE**

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Los Angeles County Department of Mental Health (LAC-DMH). Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. Our *Notice of Privacy Practices* is subject to change. If we change our Notice, you may obtain a copy of the revised Notice by visiting our website (*http//www.dmh.lacounty.gov*)or on request from our Treatment Team.

I acknowledge receipt of the *Notice of Privacy Practices* of LAC-DMH.

Signature: _____ Date:_____

(Client/Responsible Adult)

***Responsible Adult = Guardian, Conservator, or Parent of Minor when required (See Minor Consent)**

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of Treatment Team Member:_____ Date:_____

Reasons why the acknowledgement was not obtained:

- q **Client refused to sign (see progress notes for explanation)**
- q **Other Reason or Comments:**

_____

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