

Plattsburgh State

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have been provided a copy of this *Notice of HIV/AIDS Privacy Practices* and have therefore been advised of how HIV-related information about me may be used and disclosed by health care facilities and operations of the State University of New York, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information and genetic information.

Signature of Client or Personal Representative

Print Name of Client or Personal Representative

Date

Description of Personal Representative's Authority

Notice of Privacy Practices Version Number

Notice of Privacy Practices Date