CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office and on our website. The notice will contain the effective date on the bottom left-hand corner of each page.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or other offices set forth below. To file a complaint with our office, contact Galion City Health Department, Director of Nursing, 113 Harding Way East, Galion, Ohio 44833. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

You also may file a written complaint with any of the following:

- The Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue SW, Washington D.C., 20201 or call 1-877-696-6775; or
- The Office for Civil Rights, U.S. Department of Health and Human Services at 200 Independence Avenue SW, Room 509F, HHH Building, Washington D.C., 20201 or call OCR's hotline – voice at 1-800-368-1019, or e-mail at ocrmail@hhs.gov; or
- Attorney General for State of Ohio at 30 E. Broad St., 17th Floor, Columbus, OH 43215 or by e-mail at ohioattorneygeneral.gov/Contact.

** If you have any questions about this notice, please contact Galion City Health Department's Director of Nursing/HIPAA Privacy Officer at 419-468-1075.

Written Acknowledgement

I acknowledge that I have reviewed and was offered the Notice of Privacy Practices issued by the Galion City Health Department which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I requested.

Patient Name: _____
Last First Middle (Previous Last Name)

Address: _____
Street City State Zip

Can we send private mail to this address? ☐ Yes ☐ No Patient Date of Birth: _____

Preferred Phone #: _____ Can we leave a message? ☐ Yes ☐ No

Alternate Phone #: _____ Can we leave a message? ☐ Yes ☐ No

Your Name (print): _____ Relationship to Patient: _____

Patient/Parent/Representative Signature: _____ Date: _____

Date Reviewed: _____ Reviewed By: _____
Date Reviewed: _____ Reviewed By: _____
Date Reviewed: _____ Reviewed By: _____
Date Reviewed: _____ Reviewed By: _____