The UNIVERSITY of OKLAHOMA
Health Sciences Center
Student Counseling Services

ACKNOLWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the University of Oklahoma's ("OU") Notice of Privacy Practices ("Notice"):

- It tells me how OU will use my health information for the purposes of treatment, payment for treatment, and OU's health care operations.
- The Notice explains in more detail how OU may use and share my health information for purposes other than treatment, payment, and health care operations.
- OU will also use and share my health information as required/permitted by law.
- If I am an OU student receiving health services, I consent to OU using and disclosing my treatment/education records maintained by OU for the purposes detailed in OU's Notice of Privacy Practices.

Patient's Complete Legal Name: _____
(Please print)

Patient's DOB: _____

Signature: _____ Date: _____
(Patient or Legally Authorized Representative*)

* May be requested to show proof of representative status