The UNIVERSITY of OKLAHOMA
Health Sciences Center
Student Counseling Services

Acknowledgement 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"):

- The Notice 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 or education records maintained by OU for the purposes detailed in the Notice.

Client's complete legal name: ____
(Please print.)

Client's OUHSC ID #: ______________________________

Client's Date of Birth: _______________________________

Signature of Client: ________________________________ Date: ___________________

Signature of legally authorized guardian or representative* if client is a minor:

____ Date: ___________________

Relationship of Guardian or Representative to Patient: _______________________________

*May be requested to show proof of representative status

Rev 07/2019 File in Client Chart