



SOUTHEAST IOWA LINK (SEIL)
MENTAL HEALTH AND DISABILITY SERVICES REGION

DES MOINES, HENRY, JEFFERSON,
KEOKUK, LEE, LOUISA, VAN BUREN
& WASHINGTON COUNTIES

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE FOR HEALTH
CARE PROVIDERS AND HIPAA COVERED ENTITIES**

I, _____, do hereby
acknowledge receipt of a copy of the Notice of Privacy Practice, Policy and Procedure.

Signature of Individual

Date

**IN THE EVENT THIS NOTICE IS RECEIVED BY THE INDIVIDUAL'S PERSONAL
REPRESENTATIVE**

Signature of personal representative

Date

Legal authority of personal representative