Passageway

Acknowledgement of Receipt of Passageway's "Notice of Privacy Practices"
and Polk County Health Services' "Privacy of Information About Your Health" documents.

My signature below acknowledges my receipt of the Notice of Privacy Practices and Privacy Information about Your Health documents provided to me by Passageway. If I am unable to read or comprehend the documents, I understand that I have the right to request that it be read to me by a representative of the Passageway. I understand that my care and treatment by Passageway is not conditioned upon my signing of this acknowledgement.

Name of Member: _____

_____ _____

Signature of Member/Guardian Date