ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have been made aware of Domestic Abuse Project **Notice of Privacy Practices** and that I have a right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of **Domestic Abuse Project** health care operations. The Notice also describes my rights and **Domestic Abuse Project** duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Domestic Abuse Project web site at dap@mndap.org. I may request that a copy be mailed to me by calling **612-874-7063**.

Domestic Abuse Project reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing **Domestic Abuse Project** web site listed above to view the most current version.

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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

_____

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

_____

Date

_____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY