



HIPAA Notice Acknowledgement Form 37

Client Name: _____

MR#: _____

If this acknowledgement is signed by a parent/guardian on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Individual refused or was unable to sign an acknowledgement of Privacy Practices
 Refusal Date: _____

I attest that the above information is correct.

Client/Guardian Signature

Signature Date:

Mailing Address: P.O. Box 365, Oneida, WI 54155
<https://oneida-nsn.gov/resources/health/>

Oneida Community Health Center
Behavioral Health Services
Anna John Resident Centered Care Community
Employee Health Nursing

525 Airport Rd., Oneida, WI 54155
2640 West Point Rd., Green Bay, WI 54304
2901 S. Overland Rd., Oneida, WI 54155
701 Packerland Dr., Green Bay, WI 54303

Phone: (920) 869-2711 or 1-866-869-2711
Phone: (920) 490-3790 or 1-888-490-2457
Phone: (920) 869-2797
Phone: (920) 405-4492

Fax: (920) 869-1780
Fax: (920) 490-3883
Fax: (920) 869-3238
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