



Healthcare Reform Demographics Request

Patient:

Internet E-mail Address:

Ethnicity / Race

- White
- American Indian or Alaskan Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- Middle Eastern
- Two or More Races
- Prefer Not to Answer

Preferred Language

- English
- Spanish
- German
- French
- Other: _____

Organized Health Care Arrangement Acknowledgement of Receipt of Privacy Notice

By signing below, I acknowledge that I have been provided with a copy of the Great Falls Clinic Organized Health Care Arrangement Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the OHCA and how I may obtain access to and control this information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

Signature:

Date:

Complete if you are not the patient indicated above

Patient Representative

State authority to act on behalf of patient:

OHCA USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgement not obtained:

Signature:

Date: