EXHIBIT B

Riley County Health Department

ACKNOWLDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of Riley County Health Department's Notice of Privacy Practices with the effective date of April 2019.

_____ _____

Signature of Patient/Patient Representative Patient Date of Birth

_____ _____

Relationship to Patient Printed Name of Patient

_____

Date

Original to be maintained in Patient's permanent medical record.