



ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES OF THE
OSF HEALTHCARE SINGLE AFFILIATED COVERED ENTITY

I acknowledge that I have received or been offered the Notice of Privacy Practices of the OSF HealthCare Single Affiliated Covered Entity bearing the Effective date of September 23, 2013 and Revised date of December 12, 2025. I understand that the Notice describes the uses and disclosures of my protected health information by the Covered Entities which collectively constitute the OSF HealthCare Single Affiliated Covered Entity and informs me of my rights with respect to my protected health information.

Name of Patient

Medical Record Number

Date of Birth

Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

Date

If Personal Representative, indicate relationship:

Declinations

The Individual declined to accept a copy of the Notice of Privacy Practices.

The Individual received a copy of the Notice of Privacy Practices but declined to sign an Acknowledgement of Receipt.

Signature of OSF Healthcare Representative

Name of OSF Healthcare Representative