U.S. DEPARTMENT *of* STATE

Bureau of Medical Services

Acknowledgement of Receipt
Notice of Privacy Practices

Please review the Notice of Privacy Practices and complete this form as an acknowledgment of receipt.

If you decline to provide a signed acknowledgment, MED will continue to provide treatment, and will use and disclose your protected health information for treatment, payment, and health care operations consistent with STATE-24 and the Notice of Privacy Practices.

Contact Information

First Name: ____________________ M.I.: ___ Last Name: ____________________

Email: __________________ Phone: _______________

Organizational Affiliation:

Applicant: Yes ☐ No ☐

Date of Birth: ___/___/___

Chief of Mission Employee or Eligible Family Member: Yes ☐ No ☐

Agency/Bureau: _____________ Section: _______________

Region: _____________ Post: ________________

Medical Record Number: ______________

Signature: __________________________ Date: ______________

File:
Patient Medical Record
Return Receipt to MED/Medical Records

(Rev 11/22)