

**ALL EMPLOYEES NEED TO RETURN THIS FORM**

**EACH FAMILY MEMBER 18 YEARS OF AGE OR OLDER COVERED UNDER COUNTY HEALTH INSURANCE NEEDS TO RETURN THIS FORM.**

**Section 1: Acknowledgement of Receipt of Notice of Privacy Practices (mandatory)**

I hereby acknowledge that I have received a copy of the DeKalb County Government Health Plan's Notice of Privacy Practices. A copy of this form is as valid as the original.

\_\_\_\_\_  
Print Name of Person Receiving Notice

\_\_\_\_\_  
Social Security Number

⇒ \_\_\_\_\_  
**Signature of Person Receiving Notice**

⇒ \_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
Print Employee's Name

\_\_\_\_\_  
Relationship to Employee

**Section 2: Consent to Release Information (optional)**

Effective April 14, 2004, the DeKalb County Finance Office is prohibited from exchanging information with anyone other than the individual (if they are 18 years of age or older) to whom the information pertains or a Covered Entity (i.e. physician, hospital, health plan). **If there is an individual or individuals that you would like to grant access to your account (i.e. spouse or parents), please complete the section below.** You may revoke this access at any time by submitting a written request to the Finance Office.

\_\_\_\_\_  
Print Name of Person Who Can Access My Data

\_\_\_\_\_  
Relationship to Signer

\_\_\_\_\_  
Print Name of Person Who Can Access My Data

\_\_\_\_\_  
Relationship to Signer

\_\_\_\_\_  
Print Name of Person Who Can Access My Data

\_\_\_\_\_  
Relationship to Signer

\_\_\_\_\_  
Print Name of Person Who Can Access My Data

\_\_\_\_\_  
Relationship to Signer

⇒ \_\_\_\_\_  
**Signature of Person Giving Consent**

⇒ \_\_\_\_\_  
**Date Signed**

Please return this form to: DeKalb County Finance Office  
200 N. Main Street  
Sycamore, IL 60178

Additional forms are available on the DeKalb County Infocenter and at [www.dekalbcounty.org](http://www.dekalbcounty.org).