

**NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT
(Aviso de Prácticas Privacidad)**

I acknowledge that I have received a copy of the Notice of Privacy Practices.
(Reconozco que he recibido una copia del Aviso de Prácticas de Privacidad)

- Patient (Paciente)
- Patient's Representative (Representante del Paciente)
- Patient's Guardian (Guardián del Paciente)
- Patient's Parent (Padre del Paciente)
- Other (Otro):

X _____

DATE/FECHA _____

SIGNATURE/FIRMA

MM/DD/YY

(Patient and/or Patient's guardian if a minor, or patient's representative)

(Del paciente y/o guardián del paciente si es menor de edad o representante del paciente)

FOR INTERNAL USE ONLY:

Reason Acknowledgement not signed: _____

Staff Signature/Date



UNIVERSITY PHYSICIANS HOSPITAL

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Tucson, AZ 85713
(520) 874-2000

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