



MEDICAL RECORD #

DOB

NAME

VISIT #

Notice of Privacy Practices Acknowledgement

I acknowledge that I have received a copy of the Notice of Privacy Practices. (Declaro que he recibido una copia de la Notificación de Prácticas de Privacidad.)

\_\_\_\_\_ Patient (Paciente)

\_\_\_\_\_ Patient Representative (Representante del paciente)

\_\_\_\_\_ Patient Guardian (Guardián Legal o Tutor del paciente)

\_\_\_\_\_ Patient's Parent (Padre o madre del paciente)

\_\_\_\_\_ Other: (Otra persona) \_\_\_\_\_

SIGNATURE (Patient and/or Patient's guardian if a minor, or patient's representative) FIRMA (del paciente y/o del guardián legal (tutor) si el paciente es menor de edad, o del representante del paciente)

\_\_\_\_\_ Date (Fecha)

For use by UMC staff only: Entered into IDX IP DELIVERY ATTEMPTS: Date Outcome Signature IDX Username

IP Units: Forward original to Patient Placement for IDX input (Station 11) All other areas: After IDX input, forward original to Medical Record/HIPAA