NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE:___________________

I acknowledge that I was provided with a copy of the Columbia University Medical Center Notice of Privacy Practices.

________________________________          ________________________________
Patient Name (Print)            Patient Signature

If completed by a patient’s personal representative, please print and sign your name in the space below

________________________________          _____________________________
Personal Representative (Print)         Personal Representative’s Signature

______________________________
Relationship

For Columbia University Medical Center use only.

Complete this section if this form is not signed and dated by the patient or patient’s representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Columbia University Medical Center’s Notice of Privacy Practices but was unable to for the following reason:

☐ Patient refused to sign
☐ Patient unable to sign
☐ Other __________________

_____________________________              _________________________
Employee Name                                    Date

This form should be placed in the patient’s medical record