



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