

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

We are legally required to provide you with a copy of our **NOTICE OF PRIVACY PRACTICES** the first time you receive care at UC Health. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

**Patient or Patient's Legal Representative:**

**Check appropriate box and sign.**

**Patient or Patient's Legal Representative has:**

- Patient received a Copy of the Notice of Privacy Practices.
- Patient has previously received a Copy of the Notice of Privacy Practices
- Patient does not want a Copy of the Notice of Privacy Practices

MRN: \_\_\_\_\_

Patient Name (print): \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_