UCSF Health

UNIT NUMBER

PT. NAME

BIRTHDATE

LOCATION DATE

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT OF RECEIPT

The UCSF Notice of Privacy Practice provides information about how we may use and disclose protected health information about you.

In addition to the copy we have provided you, copies of the current notice are available by accessing our website at http://www.ucsfhealth.org and may be obtained throughout UCSF Health System.

I acknowledge that I have received the Notice of Privacy Practice.

X _____
Signature of Patient or Patient's Representative

X ___ / ___ / ___
Date

X _____
Print Name

_____
Relationship to Patient

_____
Name of Interpreter (if applicable)

If written acknowledgement is not obtained, please check reason:

☐ Notice of Privacy Practice Given - Patient Unable to Sign

☐ Notice of Privacy Practice Given - Patient Declined to Sign

☐ Other _____

_____
Signature of UCSF Representative

___ / ___ / ___
Date

_____
Print Name

_____
Department

876-060 (Rev 02/20) WHITE – MEDICAL RECORD YELLOW – PATIENT OR PATIENT'S REPRESENTATIVE