

**PATIENT ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES**

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

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
If personal representative, personal representative's authority to act

**If you received this form electronically, please acknowledge receipt as directed by email.**

**For Columbia University Health Sciences use only:**

Patient ( has has not ) signed an acknowledgement of the CURRENT Notice of Privacy Practices either attached here or as documented in the IDX system.

You must complete this section if this form is not signed and dated by the patient or patient's representative and no signed acknowledgement of receipt of the current notice of privacy practices is on file in the IDX system.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

The date that you requested the signature and date: \_\_\_\_\_

The reason that the signature and date were not obtained: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_