



**RECONOCIMIENTO DEL AVISO SOBRE LAS PRACTICAS DE PRIVACIDAD PARA EL PACIENTE**

Reconozco que se me proporcionó una copia referente al Aviso de Prácticas Privadas de la Facultad del Centro Medico de la Universidad de Columbia [Columbia University Medical Center].

\_\_\_\_\_  
Nombre del Paciente

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma del paciente o representante personal

\_\_\_\_\_  
Si tiene representante personal, autoridad para actuar de representante

**Si ha recibido este formulario electrónicamente, por favor reconocerlo como dirigido por correo electrónico (vía Internet)**

**For Columbia University Medical Center use only:  
Para uso exclusivo de la Facultad del Centro Medico de la Universidad de Columbia:**

**For Columbia University Medical Center 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:  
\_\_\_\_\_  
\_\_\_\_\_