Oregon Health & Science University
Hospitals and Clinics

MR1449

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE OHSU NOTICE OF PRIVACY PRACTICES.

_____ _____ Time: _____
Patient Signature Date

_____
Print Patient Name

_____ _____ Time: _____
Parent, Guardian, Responsible Party, Legal Representative Signature (if applicable) Date

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The following information is needed to process this form. If there is a label attached to the upper right hand corner of this form that includes your correct information, you do not need to complete the following information; however, please correct any incorrect information on the label.

_____
Patient Date of Birth

_____
Patient Social Security Number *(optional)*

_____
Patient Medical Record Number (from patient card)