Oregon Health & Science University
Hospitals and Clinics

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

Patient Signature _____ Date _____ Time _____

Print Patient Name _____

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

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) _____

MR1449

LARGE TYPE VERSION