

**RECEIPT OF UNMHSC PRIVACY NOTICE**

I, the undersigned, acknowledge receipt of the UNMHSC  
Notice of Privacy Practices on \_\_\_\_\_, 20\_\_\_\_\_.  
Month day year

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Printed Name of Patient or Representative

\_\_\_\_\_  
Relationship to Patient

If patient **refused** or is **unable** to acknowledge please explain why:

\_\_\_\_\_  
Printed Name of UNMHSC employee

\_\_\_\_\_  
Department

\_\_\_\_\_  
Signature of UNMHSC employee

Place  
Patient  
Barcode here