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

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Print Patient Name

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

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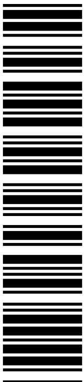
The following information is needed to process this form. If there is a label attached to the upper right hand corner of this form that includes your correct information, you do not need to complete the following information; however, please correct any incorrect information on the label.



____
Patient Date of Birth

MR1449

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Patient Social Security Number *(optional)*

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Patient Medical Record Number
(from patient card)