UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

Effective Date: September 20, 2013

PATIENT ACKNOWLEDGMENT OF RECEIPT OF THE UNIVERSITY OF MIAMI HEALTH SYSTEM NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the University of Miami Health System Notice of Privacy Practices.

_____ _____

Patient Name (Print) Date

_____

Signature of patient or personal representative/Relationship to Patient

For University of Miami use only.

Patient Name:_____ Date of Birth:_____

Medical Record Number: _____

Address: _____

_____

Complete this section if this form is not signed and dated by the patient or patient's representative.

The date that you requested the signature and date: _____

The reason that the signature and date were not obtained:

☐ Refused ☐ Emergency ☐ Other

_____

_____

_____ _____ _____ _____

Name of UM Representative (Print) Department Name Contact Number Date

University of Miami – Office of HIPAA Privacy & Security
PO Box 019132 (M-879) **hipaaprivacy@med.miami.edu**
Miami, FL 33101 **305-243-5000 1-866-366-4874**

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Form D3900001E

Revised 09/20/13

NAME: _____

MRN: _____

LAST 4 DIGITS OF SSN: _____

DOB: ____/____/____

DATE: _____ TIME: _____