NYU Langone Medical Center
Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

By signing this form, I acknowledge that I have received a copy of NYU Langone Medical Center's Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____

Personal Representative's Name (if applicable): _____

Personal Representative's Authority (e.g., parent, guardian, health care proxy):

_____

Effective as of 01/01/2016.