

Oregon Health & Science University Hospitals and Clinics



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE

Page 1 of 1 Patient Identification I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE OHSU NOTICE OF PRIVACY PRACTICES. Time: Patient Signature Date Print Patient Name Time: Parent, Guardian, Responsible Party, Date Legal Representative Signature (if applicable) 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)