SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn

Name:

MR#:

(Please affix label or print)

N.S.:

Service/Dr:

HIPAA PRIVACY FORM
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

This form will be provided to you upon registration. In the case of a medical emergency, this form will be provided to you as soon as reasonably practicable after your emergency treatment is over.

Name of Patient/ Personal Representative: _____

You are entitled to our **Notice of Privacy Practices** describing how your health information can be used and disclosed by SUNY Downstate Medical Center Health Science Center at Brooklyn and how you can obtain access to and control this information.

Our Notice of Privacy Practices will be provided to you upon registration or admission. It is also posted in our registration areas and is available on our website at www.downstate.edu.

We have additional Notices of Privacy Practices for HIV, mental health and alcohol & substance abuse information. You can request a copy of these notices at any time.

_____	_____	_____	_____
Patient/Surrogate Name (Print)	Signature	Date	Time

_____
Relationship to Patient

For SUNY Downstate Employee Use Only:

____ Patient would not acknowledge receipt of Notice of Privacy Practices. Documentation of good faith effort to obtain acknowledgement and reason not obtained:

_____

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