SUNY DOWNSTATE Medical Center

**HIPAA PRIVACY FORM**
**NOP 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: _____

## I. Notice of Privacy

You are entitled to our **Notice of Privacy Practices** describing how your health information can be used and disclosed by SUNY Downstate Medical Center 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.

*By signing below, I acknowledge that I received the Notice of Privacy Practices.*

_____ _____
SIGNATURE OF PATIENT/ PERSONAL REPRESENTATIVE DATE

_____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

**For SUNY Downstate employee use only:**
__ Patient would not acknowledge receipt of NPP. Documentation of good faith effort to obtain acknowledgement and reason not obtained:
_____
_____
_____

## II. Individuals Involved in Care

Please identify family members, relatives or close personal friends that we may share your health information with who are involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition here at the hospital or about the unfortunate event of your death.

| | |
|---|---|
| Name: _____ | Name: _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| _____ | _____ |
| Phone #: _____ | Phone #: _____ |
| Relation: _____ | Relation: _____ |