UNIVERSITY PHYSICIANS
BROOKLYN, INC.

HIPAA PRIVACY FORM
NOP ACKNOWLEDGEMENT

This form will be provided to you upon registration.

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 University Physicians of Brooklyn, Inc. (UPB) and how you can obtain access to and control this information.
Our Notice of Privacy Practices will be provided to you upon registration. It is also posted in our practices.

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 UPB 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 or about the unfortunate event of your death.

Name: _____ Name: _____
Address: _____ Address: _____
_____ _____
_____ _____
Phone #: _____ Phone #: _____
Relation: _____ Relation: _____