Receipt of Notice of Privacy Policies

Patient Name _____

Clinic Name _____

Patient Account Number _____

Pacific University respects your privacy and only uses or discloses your medical information when necessary, appropriate, required by law, or with your permission. Our Notice of Privacy Practices describes potential uses and disclosures of your health information by our health care clinics and outlines your medical privacy rights.

I acknowledge that I have received the *Notice of Privacy Practices* from Pacific University Clinic.

_____ _____

Patient Signature Date

If you are signing as a personal representative of the patient, please describe your relationship to the patient and the source of authority, if applicable, to sign this form (for example, parent, guardian, named agent under health care power of attorney):

_____ _____

Relationship to Patient Print Name

_____ _____

Signature of Patient Representative Date

Source of Authority: _____

Approved: 04/30/2013
Reviewed:
Revised: 08/16/2013; 10/2017, 06/2018