Manhattan School of Music

Acknowledgment of Receipt of Notice of Privacy Practices

(Complete lines marked with *)

* Student/Patient Name: _____

* Date of Birth: ____/____/_____

I have received a copy of the MSM Campus Health Nurse Office "Notice of Privacy Practices" and/or agree that I understand the information.

*_____ *_____

Student/Patient Signature Date

(Please complete section below if student/patient is a minor)

_____ _____

Signature of Parent/Guardian or Personal Representative Date

_____

Relationship to Patient

Signature not obtained:

- ☐ Patient declined
- ☐ Healthcare emergency
- ☐ Other_____

_____ _____

Staff Member's Name (please print) Date

_____

Department

(Retain this document in the patient's medical record for 6 years in accordance with the HIPAA Privacy Rule)

revised: 07/2015