Mount Sinai

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (NOPP)

By signing below I acknowledge that I have been provided a copy of the Notice of Privacy Practices (NOPP). I have therefore been advised of how health information about me may be used and disclosed by the hospitals and facilities listed in the beginning of this notice as well as how I may obtain access to and control over this information.

Last name _____ First name _____ MI _____

Date of birth _____

Signature of patient or authorized representative _____

Name of authorized representative _____ Relationship to patient _____

Date _____

FOR OFFICE USE ONLY

I was not able to obtain the patient's acknowledgment of receipt of the NOPP upon registration because:

- ◯ The patient refused to sign despite good faith efforts
- ◯ The patient was unaccompanied and not alert and oriented
- ◯ The patient was unaccompanied and needed emergency care
- ◯ Other, (explain):

_____

Employee name _____ Date _____

Employee signature _____ Employee title _____

- ◯ Acknowledgment subsequently obtained, (see above).