IOWA
HEALTH CARE

Name: _____

Hosp. #: _____

PRIVACY NOTICE ACKNOWLEDGEMENT FORM

By signing below, I agree I have received and/or been offered a copy of the University of Iowa Health Care Notice of Privacy Practices. I have the right to review the Notice of Privacy Practices prior to signing this form.

University of Iowa Health Care has the right to change the Notice of Privacy Practices. The revised Notice of Privacy Practices will be posted within University of Iowa Health Care, University of Iowa Student Health Services, online at www.uihc.org/privacy-notice, and paper copies will be available at registration and check-in locations.

Signature: _____ **Date:** _____ **Time:** _____
(Patient or person legally authorized to consent for patient)

_____ _____
(Printed name of patient or legally authorized person signing) (Relationship to patient or legally authorized person)

This completed form must be filed in the medical record.