IOWA HEALTH CARE

Name: _____

Hosp. #: _____

## NONDISCRIMINATION AND LANGUAGE ASSISTANCE NOTICES ACKNOWLEDGEMENT FORM

By signing below, I agree I have received and/or been offered copies of University of Iowa Health Care's Nondiscrimination and Language Assistance Notices. I have the right to review both the notices prior to signing this form.

University of Iowa Health Care has the right to change both notices. The revised Notice of Nondiscrimination will be posted online at https://uihc.org/notice-nondiscrimination. The revised Notice of Language Assistance will be posted online at https://www.healthcare.uiowa.edu/marcom/uihc/visitors/point_to_your_language.pdf. Paper copies will be available at 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.