UNIVERSITY of IOWA HEALTH CARE

Patient Name:	
Medical Record Number:	

Receipt of Privacy Notice Form

By signing this form I state that I have received the University of Iowa Health Care Privacy Notice. I have the right to review the Privacy Notice prior to signing this form.

University of Iowa Health Care has the right to change the Privacy Notice from time to time. The revised Privacy Notice will be posted within University of Iowa Hospitals and Clinics, and Student Health Services facilities, on the University of Iowa Health Care web site, and paper copies will be available at all registration and check-in points.

Signature of Patient
Or Legal Representative: _____ Date: _____

Relationship, if not the patient: _____

********** *UIHC Use Only* **********

For failure to obtain acknowledgment, check the appropriate reason and provide details as applicable:

- ❑ Substantial communication barriers
- ❑ Refusal to sign
- ❑ Medical barrier, specify_____
- ❑ Mailed to patient
- ❑ Other, specify_____

Additional details:

_____

_____

_____

UIHC Staff Signature: _____ Date: _____

Printed name: _____ Title: _____

Department: _____

This completed and signed document must be recorded and scanned in GE.