Receipt of Notice of Privacy Policies

Patient Name

Clinic Name

Patient Account Number

Pacific University respects your privacy and only uses or discloses your medical information when necessary, appropriate, required by law, or with your permission. Our Notice of Privacy Practices describes potential uses and disclosures of your health information by our health care clinics and outlines your medical privacy rights.

I acknowledge that I have received the Notice of Privacy Practices from Pacific University Clinic.

Patient Signature ___________________________ Date __________

If you are signing as a personal representative of the patient, please describe your relationship to the patient and the source of authority, if applicable, to sign this form (for example, parent, guardian, named agent under health care power of attorney):

Relationship to Patient ___________________________ Print Name __________

Signature of Patient Representative ___________________________ Date __________

Source of Authority: ___________________________

Approved: 04/30/2013
Reviewed:
Revised: 08/16/2013; 10/2017, 06/2018