For addressograph plate

JOHNS HOPKINS INSTITUTIONS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
收到隐私惯例通知的承认书

I acknowledge that I have received a copy of the Johns Hopkins Notice of Privacy Practices.
我承认已收到约翰.霍普金斯隐私惯例通知的复印件。

Patient Name: ____
病人姓名：
(first/ 名) (m. initial/ 中间名的首字母) (last/ 姓)

Signature: ______________________ **Date:** __________________
签名： 日期：

Medical Record #: ____
病历号码：

Birth Date: ____________________
出生日期：

If you are NOT the patient but are signing on behalf of the patient complete the following:
如果你不是病人但代表病人签字，请完成下列各项：

I, ___________________________, confirm that I am the representative for the patient
我 (insert your name/ 插入你的姓名) 确认，根据以下我与病人的关系，我代表病人
based on the following relationship to the patient:

____

(state relationship, for example—parent, spouse, guardian)
（说明关系，例如**--**父或母，配偶，监护人）

Representative's Signature:
代表人签字： __________________________ **Date:** ______________
日期 ：**(Required/ 要求的***)*

Address: ______________________________________ Phone: __________________
地址： 电话：