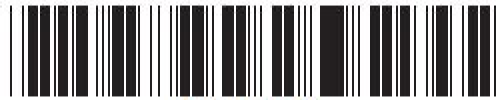

JOHNS HOPKINS INSTITUTIONS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Johns Hopkins Notice of Privacy Practices.

Patient Name: ____ **Birth Date:** _______________
(first) (m. initial) (last)

Address: ____ **Phone #:** __________________
(street address)

____ **Medical Record #:** __________
(city) (state) (zip code) (if known)

Signature of Patient Only: ___________________________________ **Date**: ______/______/______
(Required)

If you are NOT the patient but are signing on behalf of the patient complete the following:

I, _________________________________, **confirm that I am the representative for the patient based on the following relationship to the patient:**
(insert your name)

____
(state relationship, for example – parent, spouse, guardian)

Representative's Signature: ________________________________ **Date**: ______/______/______
(Required)

Address: ____ **Phone #:** __________________
(street address)

____
(city) (state) (zip code)