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)