Medical Record Number

Comprobante de haber recibido la *Notificación de prácticas de privacidad*

University of Mississippi Medical Center

Effective Date: January 1, 2020

Acepto haber recibido una copia de la *Notificación de prácticas de privacidad* de UMMC.

Nombre del paciente en letra de molde _____ Fecha _____

Firma del paciente/representante legal _____

Describa quién es su representante legal _____

UMMC Use Only

The following should be completed only if the patient cannot sign or refuses to sign the acknowledgement

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but UMMC was unable to obtain acknowledgement because:

_____

Employee signature _____ ID number _____

Date _____