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 ______________