UNIVERSITY OF
ROCHESTER
MEDICAL CENTER

STRONG HEALTH

Standard Register ®

Acknowledgement of Receipt of Notice of Privacy Practices

- ☐ Strong Memorial Hospital
- ☐ Highland Hospital
- ☐ Eastman Dental Center
- ☐ The Highlands of Pittsford
- ☐ The Highlands of Brighton
- ☐ Primary Care Network Practice: ______________
- ☐ URMFG ______________________________
- ☐ Other: ______________________________

Patient Name: ______________________________________
(please print)

DOB: ______________________________

Medical Record #: __________________________________

I have been provided with the URMC/Strong Health Notice of Privacy Practices.

Patient's Signature:____ Date: ________________

OR

Signature of personal representative:____

Relationship to patient:______________________________________ Date: ________________

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If signature not obtained, please indicate reason:

- ☐ Patient Declined
- ☐ Emergency Situation
- ☐ Other:____

Staff Member's Name (please print): ______________________________________

Department:____

Date:____

(Note: This document must be retained for 6 years in accordance with the HIPAA Privacy Rule)

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