NOTICE OF PRIVACY PRACTICES RECEIPT
HACKENSACK UNIVERSITY MEDICAL GROUP

I, _____ acknowledge receiving the Notice of Privacy Practices. I also acknowledge that future revisions of this notice will be available on the Forest Healthcare website www.foresthealthcare.com or upon request.

☐ This pertains to the **HIPAA- NOTICE OF PRIVACY ACT GUIDELINES.** I have received the privacy act guidelines pamphlet and listed all family members who can actively participate in my care planning. I understand that if I do not list these individuals; my patient information or the planning of my care will not be released or planned without my consent.

_____ relationship _____ phone#
_____ relationship _____ phone#
_____ relationship _____ phone#

Signature: X_____

Date signed: _____/_____/_____

Witness Signature: X _____

Date signed: _____/_____/_____