

Medical Record Number

**University of Mississippi
Medical Center
Acknowledgement of Receipt
of Notice of Privacy Practices**

Effective Date: January 1, 2020

I agree that I have received a copy of the UMMC Notice of Privacy Practices.

Print patient's name _____ Date _____

Signature of patient or representative _____

Description of personal representative's authority _____

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 _____