



## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA). In this notice I was advised of how health information about me may be used and disclosed by NYU Langone Medical Center, which includes both NYU Hospitals Center and NYU Faculty Group Practice and their staff. I was also told how I may obtain a copy of this information and correct errors in my health information.

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**Print Name of Patient**

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**Signature of Patient (or Financially Responsible Party)**

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**Relationship to Patient**

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**Date**