UNIVERSITY OF MASSACHUSETTS AT AMHERST

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Patient First Name _____

Patient Last Name _____

Patient Date of birth _____

Signature _____

Date _____

_____
Parent/guardian name – please print

_____
Parent/guardian signature and date
(must sign if patient is under 18)

University Health Services
University of Massachusetts
Amherst, MA 01003
413-577-5000