Northwell Health℠

# Acknowledgement of Receipt

ADDRESSOGRAPH

*I have received a copy of the Provider's Notice of Privacy Practices.*

Patient/Agent/Relative/Guardian* (Signature) Date / Time

Print Name Relationship if other than patient

Telephonic Interpreter's ID # Date / Time

**OR**

Signature: Interpreter Date / Time

Print: Interpreter's Name and Relationship to Patient

Witness to signature (Signature) Date / Time

Print Witness Name

## PROVIDER USE ONLY

_____ Patient or patient representative refused to sign/accept Notice of Privacy Practices

_____ Patient unable to sign

Signature Date / Time

* The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 or is otherwise incapable of signing.