

JOHNS HOPKINS INSTITUTIONS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Johns Hopkins Notice of Privacy Practices.

Patient Name: _____
(first) (m. initial) (last)

Signature: _____ **Date:** _____

Medical Record #: _____

Birth Date: _____

For healthcare agent/court appointed guardian/surrogate/parent/informal kinship care relative, I,
(circle one of the above)

_____, confirm that I am the representative for the patient as circled
(insert your name)

above.

Representative's Signature: _____

Address: _____ **Phone:** _____

If you are the healthcare agent, court appointed guardian, or relative providing informal kinship care, please attach proof of your authority to act on behalf of the patient.