Institute of

Sleep Medicine

Towson Campus
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Phone: 410.238.1673

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Notice of Privacy Practices effective Wednesday, September 29, 2004.

____ ______________________

Signature of Patient Date

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Printed Name of Patient

____ __________________

Print Name of the Person with whom information may be shared Relationship

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Signature of Parent/Guardian of Minor Patient

Good faith effort to obtain acknowledgment of the above named patient.
The patient declined to sign the above acknowledgement after being requested to do so.

Other: ____

Staff Member Signature ______________________________ Date: ________________