



# NYU Langone Health Notice of Privacy Practices

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

By signing this form, I acknowledge that I have received a copy of NYU Langone Health's Notice of Privacy Practices.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Personal Representative's Name (if applicable): \_\_\_\_\_

Personal Representative's Authority (e.g., parent, guardian, health care proxy):  
\_\_\_\_\_

Effective as of 3/1/24.