



NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

Weill Cornell Medicine, NewYork-Presbyterian, and Columbia University participate in an Organized Health Care Arrangement (OHCA). This allows us to share health information to carry out treatment, payment and joint health care operations relating to the OHCA, including integrated information system management, health information exchange, financial and billing services, insurance, quality improvement, and risk management activities. Organizations that will follow this notice include Weill Cornell Medicine, NewYork-Presbyterian sites, Columbia University and their entities.

Date: _____

I acknowledge that I was provided with a copy of the Weill Cornell Medicine, NewYork-Presbyterian, and Columbia University Notice of Privacy Practices.

Patient Name (Print): _____

Patient (Signature): _____

If completed by a patient's personal representative (or if the patient is a minor), please print and sign your name in the space below.

Personal Representative/Guardian (Print): _____

Personal Representative/Guardian (Signature): _____

Relationship to the patient: _____

Please check this box if you wish to have your name, location, and health condition removed from the hospital directory that is used to disclose your admission status to external party queries. (For NYP Use Only)