NYU Langone Medical Center
Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I have received a copy of NYU Langone Medical Center's Notice of Privacy Practices.

By providing my email address, I consent (agree) to receiving notifications, including breach notifications, through the Medical Center's secure email messaging system.

Patient Name: _____

Personal Representative Name (if applicable): _____

Personal Representative's Authority (ex: parent, guardian, health care proxy): _____

_____

Email Address: _____

Signature: _____ **Date:** _____

Effective as of 05/23/2013.