



Affiliate: Columbia University College of Physicians and Surgeons
A Planetree Hospital
A Magnet® Recognized Hospital

Health Information Portability and Accountability Act (HIPAA)

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a copy of
Stamford health System's
Joint Notice of Privacy Practices has been made available to me.

Name: _____

Signature: _____

Date: _____

Relationship to Patient (If not patient): _____

Patient's Name: _____ Patient's Date of Birth: _____