UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

UNIVERSITY OF MIAMI
MILLER SCHOOL
of MEDICINE

Fecha de Vigencia: 1 de diciembre de 2007

FORMULARIO DE INFORMACIÓN DE LA NOTICIA DE REGLAS DE PRIVACIDAD DE EL SISTEMA DE SALUD DE LA UNIVERSIDAD DE MIAMI

Yo certifico que recibí copia de la Noticia de Reglas de Privacidad de el Sistema de Salud de la Universidad de Miami.

_____ _____

Nombre del Paciente Fecha

_____

Firma de Paciente o de su Representante Personal/Relación al Paciente

Para uso exclusivo de la Universidad de Miami.

Patient Name:_____ Date of Birth:_____

Medical Record Number: _____

Address: _____

_____

Complete this section if this form is not signed and dated by the patient or patient's representative.

The date that you requested the signature and date: _____

The reason that the signature and date were not obtained:

☐ Refused ☐ Emergency ☐ Other

_____

_____

_____ _____ _____ _____

Name of UM Representative (Print) Department Name Contact Number Date

University of Miami – Office of HIPAA Privacy & Security
PO Box 019132 (M-879) **hipaaprivacy@med.miami.edu**
Miami, FL 33101 **305-243-5000 1-866-366-4874**

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE UNIVERSITY OF MIAMI NOTICE OF PRIVACY PRACTICES (SPANISH)

Form D3900001S

Revised 8/10/09

NAME: _____

MRN: _____

LAST 4 DIGITS OF SSN: _____

DOB: ____/____/____

DATE: _____ TIME: _____