Jefferson University Physicians
Department of Psychiatry and Human Behavior

Patient Name:_____Date of Birth:_____
(Please Print)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

By signing below, I acknowledge receipt of the Notice of Privacy Practices of Thomas Jefferson University ("TJU"), Thomas Jefferson University Hospitals, Inc. ("TJUH"), and Jefferson University Physicians ("JUP") (collectively referred to as "Jefferson"). In addition, by signing below, I authorize Jefferson to disclose my health information in conformance with the provisions of the Notice of Privacy Practices.

Signature:_____ Date:_____
(Patient/Parent/Legal Guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, indicate the reason why the acknowledgement was not obtained.

_____ Individual refused to sign

_____ An emergency situation prevented us from obtaining the acknowledgement

Signature of Jefferson Representative:_____

Date: _____