

**BOSTON UNIVERSITY
STUDENT HEALTH SERVICES**

Privacy Notice Written Acknowledgement

Patient Name: _____ **B.U. Id Number:** _____
 (Last) (First) (Middle)

I understand that the Student Health Services may use my health information for treatment, payment and health care operations. I have been given a copy of the Student Health Services Notice of Privacy Practices that describes how my information is used and disclosed. I understand that the Student Health Services has the right to change this Notice at any time. I may obtain a current copy of the Notice by contacting the Records Administrator for Student Health Services (the location where I received my health care services).

 Signature of Patient/ Legal Guardian or
 Personal Representative

 Date

 If signed by Personal Representative,
 Relationship to patient

 Privacy Notice Effective Date

 Witness

DOCUMENTATION OF GOOD FAITH EFFORT

Notice of Privacy and Written Acknowledgement provided to the patient/parent/ legal guardian or other personal representative, by: (check one)

- Hand Delivery
- Sent to patient/parent/ legal guardian at the address of record, or
- Sent to the patient/parent/legal guardian at the Email Address of record

Patient/parent/legal guardian or other personal representative: (check one)

- Expressly states they decline to sign Written Acknowledgement of receipt of Notice because _____
- Has not expressly declined, but has failed to return the signed Written Acknowledgement, despite the following good faith efforts to obtain the return of the Acknowledgment:

 Signature

 Date

