

# ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you are agreeing that you have received a copy of the Baylor College of Medicine Privacy Notice, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

**Receipt of Privacy Notice acknowledged by:**

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Signature

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Print name (Please print clearly)

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Date

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BCM ID# (Use DOB, if you do not know your ID#)

**Relationship to patient/employee:**

Self     Other: \_\_\_\_\_