PACE UNIVERSITY

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT FORM

I _____ acknowledge that I have received a
Print Name
copy of the University's Notice of Privacy Practices and I consent to the use of my protected health information for treatment, payment and the healthcare operations of the University as summarized in the Notice of Privacy Practices.

Signature _____ Date _____

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Please return this acknowledgment in person, by mail or fax to the office noted below.

Westchester

□ Pace University
University Health Care
Goldstein Health, Fitness & Recreation Center
861 Bedford Rd
Pleasantville, NY 10570
Fax: 914-773-3651

New York City

□ Pace University
University Health Care
41 Park Row, Room 313
New York, NY 10038
Fax: 914-346-1308

NOTE: If you are returning this form by mail, the office address is preprinted on the other side of this sheet. Please fold it in thirds, seal with staple or tape and affix correct postage. Thank you.