HarmonyHealthcare
Long Island

PATIENT ACKNOWLEDGMENT
OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION

Acknowledgement of Receipt of Notice of Privacy Practices: I acknowledge that I have been provided a copy of the Harmony Healthcare Long Island, Inc. (HHLI) Notice of Privacy Practices, which describes how health information about me may be used and disclosed by HHLI and how I may obtain access to and control the use and disclosure of this information.

Signature of Patient or Representative: _____ Date _____

Name of Personal Representative:_____
(Printed) (If Applicable)

Relationship to Patient: _____
(If Applicable)

516-296-3742
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