PACE UNIVERSITY

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT FORM

I ____________________________________________ acknowledge that I have received a 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
78 N Broadway
White Plains, NY 10603
Fax: 914-422-4056

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
1 Pace Plaza, B Level West
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.