

**LONG ISLAND UNIVERSITY CENTER FOR PHYSICAL REHABILITATION**

**Notice of Privacy Practices  
Client Acknowledgement**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date of Initial Visit: \_\_\_\_\_

I have received LIUCPR's Notice of Privacy Practices written in plain language. The Notice provides, in detail, the uses and disclosures of my protected health information that may be made by LIUCPR, my individual rights and LIUCPR's legal duties with respect to my protected health information.

I understand that LIUCPR reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain LIUCPR's current Notice of Privacy Practices on request.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to client (if signed by a personal representative, parent or guardian):

\_\_\_\_\_