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.