

**JOHNS HOPKINS INSTITUTIONS**

- \_ Johns Hopkins Hospital
- \_ Johns Hopkins Bayview Medical Center
- \_ Howard County General Hospital
- \_ Johns Hopkins Community Physicians
- \_ Johns Hopkins Home Care Group
- \_ Ophthalmology Associates
- \_ The Center of Ambulatory Services
- \_ Howard County Neonatal Services
- \_ Frederick County Neonatal Services
- \_ Johns Hopkins Emergency Medical Services
- \_ Designated health care components of The Johns Hopkins University

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**BY DECEDENT'S PERSONAL REPRESENTATIVE**

In accordance with HIPAA regulations, I acknowledge that I have received a copy of the Johns Hopkins Notice of Privacy Practices on behalf of the following individual:

**Decedent's Name:** \_\_\_\_\_

**Johns Hopkins Medical Record # (if known):** \_\_\_\_\_

**Decedent's SSN (if known):** \_\_\_\_\_ **Decedent's Birth Date:** \_\_\_\_\_

**Personal Representatives: Please provide the following information.**

I, \_\_\_\_\_, represent that I am the healthcare agent/guardian/surrogate/parent  
 (insert your name) (circle one of the above)  
**of the person named above.**

**Personal Representative's Signature:**  
 \_\_\_\_\_

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

**Address:** \_\_\_\_\_

**Telephone number(s):** \_\_\_\_\_

<p><b>INSTRUCTIONS FOR COMPLETING THIS FORM</b></p> <p><b>If you are the next of kin other than the parent of the decedent, please circle "surrogate".</b></p> <p><b>If you are the healthcare agent or guardian, please provide proof of your authority to act on behalf of the patient.</b></p>
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