University of Colorado
Advanced Reproductive Medicine

ACKNOWLEDGEMENT OF AVAILABILITY OF JOINT NOTICE OF PRIVACY PRACTICES (HIPPA)

By signing this document, I acknowledge that a copy of the joint Notice of Privacy Practices for University of Colorado, University of Colorado Health Sciences Center and University Physicians, Inc is available to me if I wish.

May we leave a message for you at home? ☐ Yes ☐ No

May we leave a message for you on your cell? ☐ Yes ☐ No

May we speak to anyone else regarding your care? ☐ Yes ☐ No

If yes,

Name: _____ Relationship: _____

_____
Signature

_____
Printed Name

_____
Date