



COLLEGE OF EDUCATION

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**UNIVERSITY OF IOWA**

Privacy Notice Acknowledgment Form

By signing this form I acknowledge that I have received the University of Iowa Privacy Notice. I have the right to review the Privacy Notice prior to signing this acknowledgment form.

The University of Iowa has the right to change the Privacy Notice from time to time. The revised Privacy Notice will be posted within the clinical and facilities, on the University of Iowa web site, and paper copies will be available at clinic check-in points.

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Patient  
or Legal Representative:** \_\_\_\_\_

**Relationship to the Patient:** \_\_\_\_\_

This will be retained with the patient record. Please return this form to the registration desk of the clinic.

For failure to obtain acknowledgment, check the appropriate reason:

- Substantial communication barriers
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Description:  
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\_\_\_\_\_  
Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Department: \_\_\_\_\_ Title: \_\_\_\_\_