THE NEW YORK HOTEL TRADES COUNCIL
HEALTH CENTER, INC.
THE HOTEL ASSOCIATION OF NEW YORK CITY, INC.

New York Hotel Trades Council and Hotel Association of New York City, Inc. – Health Center

Patient Information Acknowledgement Form

I, _____ DOB: ___/ ___/ _____
Print: Patient's Last Name/First Name

Do hereby acknowledge receipt of the following information:

- Patient's Rights and Responsibilities
- HIPAA Notice of Privacy Practices
- Advanced Directives - Appointing Your Health Care Agent:

I further acknowledge that I have been informed that if I have any questions on this material or am interested in completing a Health Care Proxy that I am to discuss it with my Healthcare Provider /and or nurse.

_____ _____ ___/ ___/ _____
Signature of Patient or Legal Representative Medical Record # Date

_____ _____ /_____ ___/ ___/ _____
Signature of Witness Print Name / Title of Witness Date

Advanced Directives are available in other languages as follows: Spanish- https://www.health.ny.gov/publications/1431.pdf Chinese- https://www.health.ny.gov/publications/1401.pdf Haitian Creole- https://www.health.ny.gov/publications/1408.pdf Korean- https://www.health.ny.gov/publications/1410.pdf Russian- https://www.health.ny.gov/publications/1402.pdf	Patient Bill of Rights are available in other languages as follows: Spanish- https://www.health.ny.gov/publications/1516.pdf Chinese- https://www.health.ny.gov/publications/1517.pdf Creole- https://www.health.ny.gov/publications/1518.pdf Korean- https://www.health.ny.gov/publications/1520.pdf Russian- https://www.health.ny.gov/publications/1519.pdf