
## ☐ Verification Of Review of Patient Bill of Rights

I certify that i have been offered/given a copy of the Patient Bill of Rights for my review and any questions that i may have had regarding them have been answered to my satisfaction.

## ☐ Acknowledgement of Privacy Notice

I acknowledge that i have been offered/given a copy of the Privacy Notice as a requirement of the federal law (HIPPA).

**Patient's Signature:** _____ **Date:** _____

**Witness:** _____

**Pilgrim Medical Center Representative**

**Patient's signature indicates awareness/receipt of all of the above. Additional copies are available upon request or may be found in our website. ( www.pilgrimmed.com )**