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**AMBULATORY  
PATIENT NOTIFICATION RECORD**

I acknowledge that I have been given the following Notices as required by State and Federal regulations:

- New York State Patients' Bill of Rights
- Continuum Notice of Privacy Practices
- New York State Health Care Proxy
- Continuum Summary of Policy on Advance Directives
- Continuum Patient Information on Pain Management

and I consent to share my health information for payment, treatment and hospital operations purposes.

\_\_\_\_\_  
Patient/Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Representative Relationship to Patient

\_\_\_\_\_  
Date

Patient:     Unable to sign  
               Refuses to sign

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date