



**Attachment 8: Patient Rights and Responsibilities Acknowledgement**

By signing below I acknowledge that I have read and understand these Patient Rights and Responsibilities:

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

Print Patient/Member Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Person Signing (if other than the patient/member):

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_