INOVA

1PTRCR

Each person who is a patient or resident in a hospital or other facility operated, funded, or licensed by the **Virginia Department of Behavioral Health and Developmental Services** shall be assured his or her legal rights and care consistent with human dignity insofar as it is within the reasonable capabilities and limitations of the Department or Licensee and is consistent with sound therapeutic treatment.

I acknowledge that I have received my statement of Patient Rights and the contact information for my local human rights representative.

Patient (signature)	Date	Time
Witness (signature)	Date	Time
Witness (print name)	Relationship	

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Behavioral Health Services

Acknowledgement of Patient Rights

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ IMG: _____

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