Patient Name: _____

MRN: _____

Date: _____

St.JosephHealth Medical Group

NOTICE OF PRIVACY PRACTICE ACK – NOR CAL

HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice and for you to sign as acknowledging receipt of this brochure.
http://www.stjhs.org/documents/SJH_Notice-of-Privacy-Practices-June2014.pdf?furl=sjhprivacypractices

_____ _____

Patient Name (Print) Date of Birth

_____ _____

Patient /Representative Signature Relationship to Patient Date

You may share information about my condition with:

REQUEST FOR ALTERNATIVE MEANS OF COMMUNICATION

You may request to receive confidential communications involving your protected health information (PHI) by an alternative means or at alternative addresses. We may not ask you the reason for your request. We will accommodate all reasonable requests. If you make a special request, you must give us an alternative address or other method of contacting you (phone number etc,). Please specify how or where you wish to be contacted:

☐ Leave a detailed message on Answering Machine #: _____

☐ Send communication via fax #: _____

Signature of patient or representative: _____

Relationship to patient _____ Date: _____

Witness: _____ Date: _____