Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
LUCILE PACKARD CHILDREN'S HOSPITAL
STANFORD, CALIFORNIA 94305

ADMIN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Stanford Hospital and Clinics and Lucile Packard Children's Hospital. Our Notice provides information about how we may use and disclose the health information that we maintain about you. We encourage you to read our full Notice.

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge receipt of the *Notice of Privacy Practices* of Stanford Hospital and Clinics and Lucile Packard Children's Hospital.

Patient, Parent or Personal Representative

Signature:_____ Print Name:_____ Date:_____ Time:_____

If other than the patient, specify relationship: _____

If interpreted: _____ _____ _____
Interpreter Signature *Print Name* *Language*

_____ _____ _____
Date *Time* *Position/Relationship to Patient*

DATOS PRINCIPALES • ACUSO DE RECIBO DE LA NOTIFICACIÓN DE PRÁCTICAS DE PRIVACIDAD

Al firmar este formulario, usted confirma haber recibido la *Notificación de las Prácticas de Privacidad* de Stanford Hospital and Clinics y Lucile Packard Children's Hospital. Nuestra Notificación proporciona información sobre cómo podemos usar y divulgar la información de salud que mantenemos sobre usted. Le recomendamos leer nuestra Notificación completa.

ACUSO DE RECIBO: Confirmo haber recibido la Notificación de las Prácticas de Privacidad de Stanford Hospital and Clinics y Lucile Packard Children's Hospital.

Paciente, Padre, Madre, Representante Personal

Firma:_____ Nombre Impreso:_____ Fecha:_____ Hora:_____
Signature *Print Name* *Date* *Time*

Si no firma el paciente, indique su relación con él:_____

FOR HOSPITAL USE ONLY: INABILITY TO OBTAIN ACKNOWLEDGEMENT

If the Hospital is not able to obtain the patient's acknowledgement, record the good-faith effort made to obtain acknowledgement, and the reason acknowledgement was not obtained:

Effort to obtain acknowledgement:

❑ In-person request ❑ Request via mail (send copy of letter to HIMS for inclusion in patient's record)

❑ Request via e-mail ❑ Other:_____

Reason acknowledgement was not obtained:

❑ Patient refused to sign ❑ Patient did not return acknowledgement via mail, e-mail

❑ Patient unable to sign ❑ Other:_____

Staff: _____ _____ _____ _____
Signature *Print Name* *Date* *Time*