ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES	Sutter Pacific Medical Foundation

ACKNOWLEDGEMENT OF RECEIPT

I have received the notice of Privacy Practices. This Notice provides information about how my protected health information may be used or disclosed.

Date	Time	Signature (Patient/Representative)

If signed by other than the patient, print name and relationship.

Name	Relationship

Witness(es) (2) only required for telephone consent, physical inability to sign, or signature by mark:

Date	Time	Witness	Witness

INABILITY TO OBTAIN ACKNOWLEDGEMENT
(Complete Only If No Signature Is Obtained)

A good faith effort has been made to obtain the acknowledgement above. At this time, the following circumstances exist:

The patient refuses to sign

The patient is not able to sign and there is no legal representative available.

Date	Time	Signature of Employee