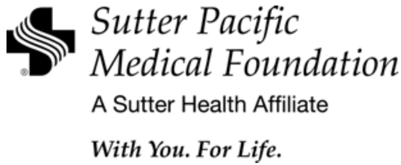

Addressograph/MR# ______________

NOTICE OF PRIVACY PRACTICES: ACKNOWLEDGEMENT OF RECEIPT

Your signature on this document acknowledges that you have received a copy of the Sutter Pacific Medical Foundation (SPMF) Notice of Privacy Practices.

Our Notice of Privacy Practices provides you with information about how SPMF may use or disclose your protected health information. The Notice also explains how you can access, amend, and restrict your protected health information. We encourage you to read it in full.

Print Name: ___________________________________ Date of Birth: _______________

Signature: _____________________________________ Date: ______________________

INABILITY TO OBTAIN ACKNOWLEDGEMENT

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the acknowledgement and the reasons why the acknowledgement was not obtained:

_____ Patient's medical condition prohibits acknowledgement at this time.

_____ Other: ____

____

Signature of
provider representative: _________________________________ Date: _______________