



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I understand that Hoag Memorial Hospital Presbyterian and its affiliates and affiliated providers ("Hoag") may share my health information for treatment, billing and healthcare operations. I have been provided a copy of Hoag's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Hoag has the right to change this notice at any time. I may obtain an additional copy by visiting the website at [www.hoag.org](http://www.hoag.org) or contacting the provider's registration desk.

I acknowledge receipt of the Notice of Privacy Practices of Hoag Memorial Hospital Presbyterian.

Patient's Name: \_\_\_\_\_

Patient/Legal Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by other than patient, indicate relationship: \_\_\_\_\_

Print Name (Legal Representative): \_\_\_\_\_

**INABILITY TO OBTAIN ACKNOWLEDGEMENT**

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Reasons why the acknowledgement was not obtained:

- Patient or Legal Representative received Notice of Privacy Practices but refused to sign Acknowledgement of Receipt.
- Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices.
- Other: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Hoag Staff Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_