Acknowledgement of Receipt of Joint Notice of Health Information Privacy Practices

By signing below, I acknowledge that I have received St. Vincent’s Joint Notice of Health Information Privacy Practices.

__________________________________________  ______________________________
Signature of Patient or Legal Representative    Date

The privacy, security and confidentiality of your health information are important to us. Please let us know how you prefer us to contact you with results, questions, or appointment reminders.

Please select and number in the order we should attempt:          Phone Number:

   __ Home phone - Can we leave a message? ☐ Yes ☐ No

   __* Cell phone - Can we leave a message? ☐ Yes ☐ No

   __ Work phone - Can we leave a message? ☐ Yes ☐ No

   __* Email: ____________________________

   __ Mail to home address

   __ Telephone and message to another person
       (Please name ______________________)

   __ Other __________________________________

Please list any other persons to whom we may discuss your healthcare treatment and/or payment information. Many patients take this opportunity to list a spouse and/or an adult child or caregiver who often participate in their healthcare decisions and payment.

Name: ____________________________ Relationship: ____________________________
Name: ____________________________ Relationship: ____________________________
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