

**CHI St. Luke’s Health Medical Group**

**HIPAA Acknowledgement of Review of Notice of Privacy Practices**

**Notification Form**

I have reviewed this office’s Notice of Privacy Practices which explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon request.

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Print Patient Name Patient Date of Birth

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Patient Signature Date

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Relationship (if not patient) Witness

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

Please indicate by using a checkmark:

\_\_ Individual refused to sign

\_\_ Communications barriers prohibited obtaining the acknowledgement

\_\_ An emergency situation prevented us from obtaining acknowledgement

\_\_ Other (Please Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Verifying Staff Member\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_