St.Vincent's HEALTH SYSTEM

Pt Name: DOB:

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: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____