

## Livermore Pleasanton San Ramon Pediatrics

### ADMIN ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Stanford Hospital and Clinics and Lucile Packard Children's Hospital. Our Notice provides information about how we may use and disclose the health information that we maintain about you. We encourage you to read our full Notice.

**ACKNOWLEDGEMENT OF RECEIPT:** I acknowledge receipt of the *Notice of Privacy Practices* of Stanford Hospital and Clinics and Lucile Packard Children's Hospital.

*Patient, Parent or Personal Representative*

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

If other than the patient, specify relationship: \_\_\_\_\_

If interpreted:	_____	_____	_____
	<i>Interpreter Signature</i>	<i>Print Name</i>	<i>Language</i>
	_____	_____	_____
	<i>Date</i>	<i>Time</i>	<i>Position/Relationship to Patient</i>

### DATOS PRINCIPALES • ACUSO DE RECIBO DE LA NOTIFICACIÓN DE PRÁCTICAS DE PRIVACIDAD

Al firmar este formulario, usted confirma haber recibido la *Notificación de las Prácticas de Privacidad* de Stanford Hospital and Clinics y Lucile Packard Children's Hospital. Nuestra Notificación proporciona información sobre cómo podemos usar y divulgar la información de salud que mantenemos sobre usted. Le recomendamos leer nuestra Notificación completa.

**ACUSO DE RECIBO:** Confirmando haber recibido la Notificación de las Prácticas de Privacidad de Stanford Hospital and Clinics y Lucile Packard Children's Hospital.

*Paciente, Padre, Madre, Representante Personal*

Firma: \_\_\_\_\_ Nombre Impreso: \_\_\_\_\_ Fecha: \_\_\_\_\_ Hora: \_\_\_\_\_  
*Signature Print Name Date Time*

Si no firma el paciente, indique su relación con él: \_\_\_\_\_

### FOR HOSPITAL USE ONLY: INABILITY TO OBTAIN ACKNOWLEDGEMENT

*If the Hospital is not able to obtain the patient's acknowledgement, record the good-faith effort made to obtain acknowledgement, and the reason acknowledgement was not obtained:*

Effort to obtain acknowledgement:

- In-person request       Request via mail (send copy of letter to HIMS for inclusion in patient's record)  
 Request via e-mail       Other: \_\_\_\_\_

Reason acknowledgement was not obtained:

- Patient refused to sign       Patient did not return acknowledgement via mail, e-mail  
 Patient unable to sign       Other: \_\_\_\_\_

Staff: \_\_\_\_\_  
*Signature Print Name Date Time*

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15-2122 (02/14)