Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Lucille Salter Packard Children's Hospital
STANFORD UNIVERSITY MEDICAL CENTER ● 725 Welch Road, Palo Alto, CA 94304

Medical Record Number

Patient Name

Date of Birth

Addressograph Stamp – Patient Name, Medical Record Number

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

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 medical information that we maintain about you. We encourage you to read our full Notice. If you have any questions about our *Notice of Privacy Practices* that our registration staff cannot answer, please contact our Privacy Office at 650-72-HIPAA (650-724-4722) or 300 Pasteur Drive, Mail Code 5202, Stanford, CA 94305-5202.

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:_____ DOB:_____

Date:_____ Time:_____ If other than the patient, specify relationship: _____

If interpreted: _____ _____ _____
Interpreter Signature *Print Name* *Language*

_____ _____ _____
Date *Time* *Position/Relationship to Patient*

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

Al firmar este formulario, usted acusa recibo de 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 revelar la información médica que mantenemos sobre usted. Le exhortamos a leer nuestra Notificación completa. Si usted tiene cualquier pregunta sobre nuestra *Notificación de Prácticas de Privacidad* que nuestro personal en la sección de registro no pueda contestar, por favor póngase en contacto con nuestra Oficina Privacidad al 650-72-HIPAA (650-724-4722) ó en el 300 Pasteur Drive, Mail Code 5202, Stanford, CA 94305-5202.

ACUSE DE RECIBO: Acuso de recibo de la Notificación de las Prácticas de Privacidad de Stanford Hospital and Clinics y Lucile Packard Children's Hospital.
Firma:_____ Nombre Impreso:_____ Fecha de nacimiento: _____

Fecha:_____ Hora:_____ 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*

15-2122 (4/03)

PLEASE EMAIL THIS FORM TO HIMS-LPCH@STANFORDCHILDRENS.ORG