



CORE DATA • NOTICE OF PRIVACY PRACTICE  
ACKNOWLEDGEMENT

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*Patient, Parent or Personal Representative*

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 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/Signature: \_\_\_\_\_ Fecha/Date: \_\_\_\_\_  
*Paciente, Padre, Representante Personal*

De ser otra persona que el paciente, especifique la relación: \_\_\_\_\_

**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: \_\_\_\_\_