ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered and/or received the Lourdes Health Network Notice of Privacy Practices.

Patient Name _____ Date _____

Referring Physician _____ Family Physician _____

_____ _____

Signature Please print name (if not patient)

_____ **Patient Date of Birth** _____

Relationship to patient (legal guardian, parent of minor, power of attorney)

PERMISSION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

❍ **I DO** wish to be called for appointment reminders at:

- ❍ Home Phone #( ) _____
- ❍ Work Phone #( ) _____
- ❍ Other Phone #( ) _____

❍ **I DO NOT** wish to be called for appointment reminders.

You may communicate with the following individuals regarding my Protected Health Information (PHI):

1. _____
   Name Relationship to patient Phone #

2. _____
   Name Relationship to patient Phone #

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:

- ❍ Individual refused to sign.
- ❍ Communication barriers prohibited obtaining the acknowledgement.
- ❍ An emergency situation prevented us from obtaining acknowledgement.
- ❍ Other: _____

LOURDES Health Network

This form is good until revoked or changed at:

LOURDES HEALTH NETWORK
520 North 4th Ave.
Pasco, WA 99301