



**Saint John's
Health Center**

Santa Monica, CA 90404

**Acknowledgement of Receipt of
Notice of Privacy Practices**

I hereby acknowledge that I have received a copy of Saint John's OHCA Notice of Privacy Practices.

Signature of patient or patient's representative

Date _____

Printed name of patient or patient's representative

Patient

Authorized Representative:

- Spouse
- Parent of a minor child
- Court appointed Conservator/legal guardian
- Registered Domestic Partner
- Durable Power of Attorney for Healthcare Agent

FOR SAINT JOHN'S HEALTH CENTER USE ONLY

If an acknowledgement for the receipt of the notice of privacy practices is not obtained, please complete the following:

Date of attempt to obtain Acknowledgement: _____

Reason Acknowledgement was not obtained:

- Patient/family member received notice but refused to sign acknowledgement
- Emergency treatment situation
- Patient was incapacitated and no family member was present
- Unable to communicate due to language barriers
- Other (please describe)

Signature of SJHC Employee

Date



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