COUNTY OF SANTA CLARA
Health System

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge you have received a copy of our ***Notice of Privacy Practices.*** Our ***Notice of Privacy Practices*** gives you information about how we may use and disclose your medical or protected health information (PHI). Please read it carefully.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, we will post the revised version in our facilities. You may obtain a copy of the latest ***Notice of Privacy Practices*** from our Registration or Admitting staff when you come to any of our facilities for services or treatment.

I hereby acknowledge receipt of the ***Notice of Privacy Practices*** of County of Santa Clara Health System (CSCHS).

Date: _____ Signature: _____
(patient/parent/conservator/guardian)

Name: _____
(please print)

==========

INABILITY TO OBTAIN ACKNOWLEDGEMENT

This portion must be completed only if no signature can be obtained. If it is not possible to obtain the individual's acknowledgement, describe good faith efforts made to obtain the acknowledgement, and the reasons why the acknowledgement could not be obtained.

_____
_____
_____
_____
_____
_____
_____

Date: _____ Signature: _____
(Representative of CSCHS)

Title: _____