

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY
PRACTICES AND PATIENT RIGHTS**

PATIENT RIGHTS

A copy of my Patients Rights has been made available to me.

NOTICE OF PRIVACY PRACTICES

A copy of St. Luke's Hospital Notice of Privacy Practices has been made available to me.

If applicable please list any individuals we may communicate with regarding your medical information.

Name _____

Phone _____

Name _____

Phone _____

Name _____

Phone _____

Signature of Responsible Party: _____

Date Signed: _____