St. Luke's
MEDICAL GROUP

PATIENT RIGHTS

A copy of my patient 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 with whom we may communicate regarding your medical information.

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

_____

Signature of Patient (Applicant) or Legal Representative Date Time

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

PATIENT NAME: _____

DOB: _____

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