☐ Hoag Medical Group ☐ Hoag Urgent Care ☐ Hoag Physician Partners ☐ Hoag Concierge Medicine ☐ Hoag Specialty Clinic ☐ Hoag at Home

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that the Hoag entity selected above and affiliates may share my health information for treatment, billing and healthcare operations. I have been provided a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand that the Hoag entity selected above and affiliates has the right to change this notice at any time. I may obtain an additional copy by contacting my provider's office selected above.

I acknowledge receipt of the Notice of Privacy Practices:

Patient Name: _____

Patient/Legal Representative Signature: _____ Date: _____

If signed by other than patient, indicate relationship to patient: _____

Print Name (Legal Representative): _____

INABILITY TO OBTAIN ACKNOWLEDGMENT

Complete only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained.

Reasons why the acknowledgment was not obtained:

☐ Patient or Legal Representative received Notice of Privacy Practices but refused to sign Acknowledgment of Receipt

☐ Patient or Legal Representative unavailable to acknowledge receipt of Notice of Privacy Practices

☐ Other: _____

Patient Name: _____

Staff Print Name: _____ Signature: _____ Date: _____