



## ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The Providence-St. John Health System Notice of Practices provides information about how protected health information about me (the patient) – including information about human immunodeficiency virus (HIV), AIDS – related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any; and psychological and social services records, including communications made by me to a social worker or psychologist (if any) – may be used and disclosed. I have been offered an opportunity to review the Notice before signing this form. I understand that the terms of the Notice may change and that I may obtain a revised copy by accessing the St John website at [www.stjohn.org](http://www.stjohn.org) or by contacting the Privacy Officer listed in the notice.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction, but if they agree, they will be bound by the agreement.

By signing this form, I acknowledge that I have been offered and/or received the Providence-St. John Health Notice of Privacy Practices.

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_

Signature of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign or is a Minor

Signature of Guardian, Patient Advocate  
Or Nearest Relative \_\_\_\_\_ Date \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Signature of Witness \_\_\_\_\_