ACKNOWLEDGEMENT OF RECEIPT  
NOTICE OF PRIVACY PRACTICES

We are legally required to give you this Notice and to get a signed statement that you received it. By signing this form, you are saying that you have received CHRISTUS Health Plan’s Notice of Privacy Practices.

CHRISTUS Health Plan’s Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us. Please review the Notice of Privacy Practices carefully.

The undersigned hereby acknowledges receipt of Notice of Privacy Practices for CHRISTUS Health Plan and each of its locations and components.

Patient's Printed Name ____________________________  Medical Record Number ____________________________

Patient Signature ____________________________  Date ____________________________

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Parent/Guardian Signature Relationship to Patient

If the patient did not sign an acknowledgement of receipt of the Notice of Privacy Practices, complete the following:

List efforts taken to get patient’s acknowledgement and reasons acknowledgement was not signed:

________________________________________

________________________________________

______________________________  ____________________________

Signature of Staff Member Location

______________________________  ____________________________

Printed Name of Staff Member Date