



# Temple Community Hospital

## ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Temple Community Hospital. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our organization at (213) 382-7252.

If you have any questions about our Notice of Privacy Practices, please contact:  
Imelda Manalac, RHIA  
Privacy Official for Temple Community Hospital

I acknowledge receipt of the Notice of Privacy Practices of Temple Community Hospital.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(Patient/parent/conservator/guardian)

## INABILITY TO OBTAIN ACKNOWLEDGMENT

To be completed 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.

Signature of Provider Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Reason: \_\_\_\_\_