

PATIENT NAME

MEDICAL RECORD NUMBER

Arrival Label



**Stanford**  
**HEALTH CARE**

855 Oak Grove Avenue, Suite 100  
Menlo Park, CA 94025

**HIPAA - NOTICE OF PRIVACY PRACTICE  
ACKNOWLEDGEMENT**

**University HealthCare Alliance**

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of University HealthCare Alliance*. Our Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read our full Notice. If you have any questions about our *Notice of Privacy Practices* that our registration staff cannot answer, please contact our Director of Compliance and Risk Management, Carlos Cruz, at 650-724-0326, or send a written inquiry to the Compliance and Risk Management Office, 855 Oak Grove Avenue, Suite 100, Menlo Park, CA 94025.

**University HealthCare Alliance (“UHA”) is a medical foundation affiliated with Stanford Health Care and Stanford Medicine. UHA contracts with a number of physician groups to provide the medical care in the UHA clinics. Neither UHA, Stanford Health Care, nor Stanford University employ the physicians in the clinics and do not exercise control over the professional services provided by the physician groups.**

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge receipt of the *Notice of Privacy Practices of University HealthCare Alliance*.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(patient/ parent/personal representative)

If other than the patient, specify relationship: \_\_\_\_\_,

**For Internal Use Only: Inability To Obtain Acknowledgement**

*If University HealthCare Alliance or its member medical group is not able to obtain the patients acknowledgement, record the good-faith effort made to obtain acknowledgement, and the reason acknowledgement was not obtained:*

Effort to obtain acknowledgement:

- In-person request
- Request via mail (send copy of letter to Medical Records for inclusion in patient’s record)
- Request via e-mail
- Other: \_\_\_\_\_

Reason acknowledgement was not obtained:

- Patient refused to sign
- Patient unable to sign
- Patient did not return acknowledgment via mail, e-mail
- Other: \_\_\_\_\_

Staff Print Name/Title/Supervisor:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_