ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Torrance Memorial Medical Center. 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 accessing our website at www.torrancememorial.org or by calling Torrance Memorial Medical Center at 310-517-4723. If you have any questions about our *Notice of Privacy Practices*, please ask your Torrance Memorial Medical Center representative.

I acknowledge receipt of the *Notice of Privacy Practices* of Torrance Memorial Medical Center.

Print Name of Patient:	
Signature of Patient or Representative:	
If Representative, give relationship:	Date:

INABILITY TO ACKNOWLEDGE RECEIPT OF NOTICE OF PRIVACY PRACTICES

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

☐ Patient is unresponsive

☐ Patient is injured

☐ Other (specify)_____

Signature of Representative:	
Date:	
TORRANCE MEMORIAL A CEDARS-SINAI AFFILIATE **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES** HIPAA FORM #2 Page 1 of 1	*Addressograph* **ADMITTING COPY**