Benewah Community Hospital
St. Maries Family Medicine
229 S 7th Street
St. Maries, ID 83861
208-245-2591

Patient Name: ____________________________ **DOB:** _______________________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received a copy of the Benewah Community Hospital/St. Maries Family Medicine Notice of Privacy Practices. I understand that a record is kept of the health care services I receive. I have the right to ask to see and copy that record. I may also ask to correct that record. I understand that this health care facility will not disclose the contents of my medical record to others unless I direct the facility to do so or unless the law authorizes or compels the facility to do so. I understand that I may get more information about my privacy frights by contacting the facility Privacy Officer.

Patient or legally authorized individual signature:	**Date:**
Printed name if signed on behalf of patient:	**Relationship: (parent, legal guardian, personal representative)**