

By signing this form, I acknowledge that I have been offered and/or received the St. John Health Notice of Privacy Practices.

Signature of Patient _____

Date _____

Time _____

Signature of Spouse _____

Date _____

Time _____

Signature of Witness _____

Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign or is a Minor

Signature of Guardian, Patient Advocate or Nearest Relative _____

Date _____

Time _____

Relationship _____

Address _____

Phone Number _____

Signature of Witness _____