Acknowledgment
Receipt of Notice of Privacy Practices

Chart #: ____________________

The **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** and the HIPAA Security Standards Final Rule which provides for the security of health information specifies a series of administrative, technical, and physical security procedures for covered entities to assure the confidentiality of **protected health information (PHI).**

We are required by law to maintain the confidentiality of health information that identifies you. The Notice of Privacy Practices describes how we may use and disclose identifiable health information, your rights and our obligations regarding the use and disclosure of protected health information. **Please ask for a copy if you would care to have one. Otherwise copies may be found to read in all waiting rooms.**

We may use protected health information for: treatment, payment, health care operations, appointment reminders, health benefits and services, those involved in your care or payment for your care, health oversight activities, lawsuits, law enforcement, upon death, national security, incarceration, research, as required by law, serious threats to health or safety. Special Circumstances: organ and tissue donation, military service, worker's compensation, and public health risks.

Regarding your health information you have the right to: a copy or to an inspection, request amendments, get a copy of the accounting of disclosures, and to complain about violations. You have a right to request restrictions to confidential communications.

Medicus reserves the right to revise our privacy notice.

By my signature I acknowledge the following:

- I have been told about the **Notice of Privacy Practices** and directed to a copy for my review. I also have been informed that I may have a copy for reference or obtain a copy upon request.
- I give my permission to receive telephone messages concerning appointment reminders.
- I give my permission to receive informational/marketing materials either by mail or email from Medicus.
  My email address is: ____________________
- **I would like my protected health information to be shared only with the following:**

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Signature of Patient / Personal Representative   Date

Print Patient / Personal Representative's Name: ____________________

Personal Representative's Relationship to the Patient: ____________________

Witness: ____________________

F-83r3.2010