Patient ID

Pelosi Medical Center

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Policy Attachment 06.09(a)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA'), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Pelosi Medical Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact the Center at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____ Signature: _____ Date: _____

**Family members or others you authorize us to discuss your protected health information with:**

Last Name: _____ First Name: _____

Tel #: _____ ☐ Spouse ☐ Son/Daughter ☐ Parent ☐ Other, specify _____

Last Name: _____ First Name: _____

Tel #: _____ ☐ Spouse ☐ Son/Daughter ☐ Parent ☐ Other, specify _____

***For Office Use Only***

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices but was unable to do so as documented below:

Reason:

_____

_____

Date: _____ Initials:_____