



## **Acknowledgement of Receipt of Privacy Practices**

This notice summarizes how health data about you may be used and shared and how you can get access to this data. **IMPORTANT NOTE:** This does not include all of the details about our privacy policy. For more details, please read the **NOTICE OF PRIVACY PRACTICES** that your practitioner has provided you.

### **I. How we may use and share health data about you:**

- a. Treatment - To give you medical treatment or other types of health services.
- b. Payment - To bill you or a third party for payment for services provided to you.
- c. Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

### **II. Disclosures where we do not have to give you a chance to agree or object:**

- a. To you
- b. As required by federal, state, or local law
- c. If child abuse or neglect is suspected
- d. Public health risks (for public health activities to prevent and control spread of disease)
- e. Lawsuits and disputes (in response to a court or administrative order)
- f. Law enforcement (to help law enforcement officials respond to criminal activities)
- g. Coroners, medical examiners and funeral directors
- h. Organ or tissue donation facilities if you are an organ donor
- i. To avert a threat to an individual or to public health safety

### **III. Disclosures where we have to give you a chance to agree or object:**

- a. Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
- b. Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

### **IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.**

### **V. You have the following rights relating to the health data we keep about you:**

- a. Right to inspect your health record and to receive a copy of your health record upon request
- b. Right to amend information in your health record you believe is inaccurate or incomplete
- c. Right to know to whom we have disclosed your health information
- d. Right to ask for limits on the health information data we give out about you
- e. Right to receive communication from us about your health information in alternate ways
- f. Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the **NOTICE OF PRIVACY PRACTICES** of this practice.

\_\_\_\_\_  
Signature of patient or person responsible for health care

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print patient name and Print name of signer

\_\_\_\_\_  
Patient Birth Date