PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT FORM

NAME _____ DOB: _____ LAST 4 DIGITS SS#: _____

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test result, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- ♥ A basis for planning my care and treatment.
- ♥ A means of communication among the many healthcare professionals who contribute to my care.
- ♥ A source of information for applying my diagnosis and surgical information to my bill.
- ♥ A means by which a third-party payer can verify that services billed were actually provided.
- ♥ A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- ♥ To object to the use of my health information for directory purposes.
- ♥ To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- ♥ To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have been given a copy of the Notice of Privacy Practices.

Patient Signature _____ **Date** _____

Witness Signature _____ **Date** _____