



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, 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 health 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 health care operations such as assessing quality and reviewing the competence of health professionals.

I understand and have been provided with an Abbreviated Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this acknowledgement. I understand that the hospital reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that the hospital is not required to agree to the restrictions requested. I understand that I may add to or revoke these restrictions at any time in writing, except to the extent that the hospital has already taken action.

Signature of patient or representative

Witness

Relationship to patient

Date

