Florida Health Care Medical Group

HIPAA PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge receipt of:

- HIPAA "Privacy Notice"

While completing my registration process I hereby acknowledge:

I have read the information contained in these documents, and I can ask my healthcare staff if I need assistance in understanding my rights, or if I would like them to explain these materials to me in more detail.

I understand the following:

1) That these materials are to inform me of my privacy rights as a patient
2) That the HIPAA "Privacy Notice" I have been given states that my personal "protected health information" (PHI) will be used and disclosed by my doctor and his staff in the routine activities of treatment, payment and healthcare operations.
3) Before any other use or disclosure of my personal protected health information is made I will be asked for my written authorization.

I understand that I have the following rights:

- To CONFIDENTIAL COMMUNICATIONS
- To REQUEST RESTRICTIONS on Uses and Disclosures of my PHI
- To REQUEST ACCESS to my personal protected health information
- To REQUEST AMENDMENTS to my personal protected health information
- To have an ACCOUNTING of any DISCLOSURES for purposes other than of treatment, payment and healthcare operations

I hereby authorize the following person(s) access to my health records:

Name: _____relationship_____

Name: _____relationship_____

Name: _____relationship_____

PATIENT SIGNATURE: _____ DATE: _____

PRINT PATIENT NAME: _____
RELATIONSHIP: _____ SELF or OTHER: _____

THIS ACKNOWLEDGEMENT EXPRIES SEVEN YEARS FROM THE DATE OF THE SIGNATURE ABOVE