HealthCare Partners.

HIPAA Summary of Notice of Privacy Practices & Acknowledgement Form

By signing below, I acknowledge that HealthCare Partners and/or a facility operated by, managed by or affiliated with HealthCare Partners or any of its affiliates or subsidiaries has/have provided me with a complete copy of its/their Notice of Privacy Practices. This is a summary of the information in the complete Notice of Privacy Practices.

My Rights. I have the right to:

- Get a copy of my paper or electronic medical record
- Request corrections to my paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of the complete Notice of Privacy Practices
- File a complaint if I believe my privacy rights have been violated

My Choices. I have some choice in the way the facility uses and shares my information as it:

- Tells family and friends about my condition
- Assists in disaster relief efforts
- Markets its services and sells my information

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for our services
- Help with public health and safety issues
- Do research
- Comply with applicable laws
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other governmental requests
- Respond to lawsuits and legal actions

I have had the opportunity to review the complete Notice of Privacy Practices prior to signing this acknowledgment.

I am aware that the facility reserves the right to change the terms of their Notice of Privacy Practices and to make new provisions effective for all protected health information that they maintain. In the event of amendment(s), the facility will make available a revised Notice of Privacy Practices on its website and at its treatment locations.

_____ _____

Patient or Personal Representative Date

_____

If Personal Representative signs, please state relationship to patient and explain authority to sign

HealthCare Partners.

This section is to be completed by the Facility Representative, if unable to obtain written acknowledgement from patient

I made a good faith effort to explain the purpose and content of the HealthCare Partners Notice of Privacy Practices to the patient or his/her representative and to obtain an acknowledgment from the patient or his/her representative that the Notice of Privacy Practices was received, but (check one):

_____ Patient or representative refused to sign.

_____ Patient was in an emergency treatment situation during first service delivery, and the Notice of Privacy Practices was provided as soon as was practicable after the emergency treatment situation passed.

_____ Other (list reason why acknowledgment was not obtained):

_____

_____

_____

_____

_____

Facility Name and Address: _____

_____

_____ _____

Employee Signature Date

_____

Print name and title of employee