

Cool Springs Internal Medicine and Pediatrics Clinic, PLLC

Privacy Practices Acknowledgment Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- obtain payment from third party payer.
- conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your notice of privacy practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notice of privacy practices prior to signing this consent. I understand that this organization has the right to change its notice of privacy practices from time to time and that I may contact this organization at any time to obtain a current copy of the notice of privacy practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

I further understand that you may contact me by telephone to remind or notify me of appointments.

You have my permission to leave routine test results on my voice mail or with a family member.

You *do not* have my permission to leave routine test results on my voice mail or with a family member.

Patient Name

Signature

Relationship to Patient

Date