

PRACTICE REQUIREMENTS

The Practice:

- (a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy with respect to your PHI.
- (b) Under the privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This notice is in effect as of 04/15/03.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to terms.

PATIENT NAME(PRINT): _____ DATE: ____/____/____

PATIENT SIGNATURE : _____
(Guardian if a minor)

NAME/RELATIONSHIP : _____
(If signed by other than patient)

FOR PRACTICE USE ONLY

Practice Documentation of Good Faith Effort to Obtain Acknowledgement

Patient's acknowledgement of this Notice could not be obtained because:

- Patient refused to sign
- Communication barrier prohibited obtaining acknowledgement
- Emergency circumstances
- Other

Details: _____

Signature of Practice: _____ Date: ____/____/____