WASHINGTON COUNTY INTERNAL MEDICINE, P.C.

PATIENT ACKNOWLEDGEMENT FORM

Patient Acknowledgment of Understanding of Washington County Internal Medicine, P.C.'s Notice of Privacy Practices.

Patient's Name:_____ Date of Birth: _____

SSN: _____ Previous Name: _____

I understand that the patient's health information is private and confidential. I understand that Washington County Internal Medicine, P.C., works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Washington County Internal Medicine, P.C., may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. [*In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.]

Washington County Internal Medicine, P.C. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgment. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Washington County Internal Medicine, P.C. may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Washington County Internal Medicine, P.C. will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices contains a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication by specified methods of communication or alternative location.

Washington County Internal Medicine, P.C. has established procedures that help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Washington County Internal Medicine, P.C. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Washington County Internal Medicine, P.C.'s "Notice of Privacy Practices".

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

May we communicate medical information with your Emergency contact person on file [ ] Yes [ ] No

Name(s) of individuals we may release relevant information regarding your care: _____