**Form 5 YCMC HIPPA Privacy Practices**

NOTICE OF PRIVACY PRACTICES YOUR CONVENIENT MEDICAL CARE REBECCA MCCLAIN, FNP-C PO BOX 4475215 NORTH STREET, WAYNESVILLE MISSOURI 65583 OFFICE : 573-774-6279 FAX:

573-774-5626

**This notice takes effect on the following date and remains in effect until we place it.**

OUR PLEDGE REGARDING MEDICAL INFORMATION

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTNANT TO US. WE UNDERSTAND THAT YOUR MEDICAL INFORMATION IS PERSONAL AND WE ARE COMMITTED TO PROTECTING IT. WE CREATE A RECORD OF THE CARE AND SERVICES YOU RECEIVE AT OUR ORGANIZATION. WE

NEED THIS RECORD TO PROVIDE YOU WITH QUALITY CARE AND SERVICES YOU RECEIVE AT OUR ORGANIZATION. WE NEED THIS RECORD TO PROVIDE YOU WITH QUALITY CARE AND TO

COMPLY WITH CERTAIN LEGAL REQUIREMENTS. THIS NOTICE WILL TELL YOU ABOUT THE WAYS WE MAY USE AND SHARE MEDICAL INFORMATION ABOUT YOU. WE ALSO DESCRIBE YOUR

RIGHTS AND CERTAIN DUTIES WE HAVE REGARDING THE USE AND DISCLOSURE OF MEDICAL INFORMATION.

OUR LEGAL DUTY

LAW REQUIRES US TO:

1. KEEP YOUR MEDICAL INFORMATION PRIVATE., 2. GIVE YOU THIS NOTICE DESCRIBING OUR LEGAL DUTIES, PRIVACY PRACTICES, AND YOUR RIGHTS REGARDING YOUR MEDICAL

INFORMATION., 3. FOLLOW THE TERMS OF THE CURRENT NOTICE.

WE HAVE THE RIGHT TO:

1. CHANGE OUR PRIVACY PRACTICES AND THE TERMS OF THIS NOTICE AT ANY TIME, PROVIDED THE CHANGES ARE PERMITTED BY LAW., 2. MAKE THE CHANGES IN OUR PRIVACY PRACTICES AND THE NEW TERMS OF OUR NOTICE EFFECTIVE FOR ALL MEDICAL INFORMATION THAT WE

KEEP, INCLUDING INFORMATION PREVIOUSLY CREATED OR RECEIVED BEFORE THE CHANGES.

NOTICE OF CHANGE OF PRIVACY PRACTICES:

* 1. BEFORE WE MAKE AN IMPORTANT CHANGE IN OUR PRIVACY PRACTICES, WE WILL CHANGE THIS NOTICE AND MAKE SUE THE NEW NOTICE IS AVAILABLE UPON REQUEST.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

THE FOLLOWING SECTION DESCRIBES DIFFERENT WAYS THAT WE USE AND DISCLOSE MEDICAL INFORMATION. NOT EVERY USE OR DISCLOSURE WILL BE LISTED. HOWEVER, WE HAVE LISTED ALL OF THE DIFFERENT WAYS WE ARE PERMITTED TO USE AND DISCLOSE MEDICAL INFORMATION. WE WILL NOT USE OR DISCLOSE YOUR MEDICAL INFORMATION FOR

ANY PURPOSE NOT LISTED BELOW, WITHOUT YOUR SPECIFIC WRITTEN AUTHORIZATION. ANY SPECIFIC WRITTEN AUTHORIZATION YOU PROVIDE MAY BE REVOKED AT ANY TIME BY WRITING TO US AT THE ADDRESS PROVIDED AT THE TOP OF THIS NOTICE.

FOR TREATMENT: WE MAY USE MEDICAL INFORMATION ABOUT YOU TO PROVIDE YOU WITH MEDICAL TREATMENT OR SERVICES. WE MAY DISCLOSE MEDICAL INFORMATION ABOUT YOU TO DOCTORS, NURSES, TECHNICIANS, MEDICAL STUDENTS, OR OTHER PEOPLE WHO ARE TAKING CARE OF YOU. WE MAY ALSO SHARE MEDICAL INFORMATION ABOUT YOU TO YOUR OTHER

HEALTH CARE PROVIDERS TO ASSIST THEM IN TREATING YOU.

FOR PAYMENT: WE MAY USE AND DISCLOSE YOUR INFORMATION FOR PAYMENT PURPOSES. A BILL MAY BE SENT TO YOU OR A THIRD-PARTY. THE UNFORAMTION ON OR ACCOMPANYING THE BILL MAY INCLUDE YOUR MEDICAL INFORMATION.

ACKNOWLEDGEMENT FORM

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICE AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

**Name:**

**Date of Birth:**

**Signature**

**Date:**