Abide Health Medical APC

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Las Vegas, NV 89117
Phone #: (725) 205-1578 Fax #: (725) 485-3749

HIPAA Privacy Practices Acknowledgment

Notice of Privacy Practices

As part of our ongoing commitment to safeguarding your health information, we are required by law to inform you of how your health information may be used and disclosed, and how you can access your information. This is done through our **Notice of Privacy Practices**, which describes how we use and share your health information, your rights regarding your health information, and our legal duties with respect to your information.

We are required to provide you with a copy of the **Notice of Privacy Practices** upon your first visit, and we may update this notice periodically.

How We Use and Disclose Your Health Information:

Your health information may be used and disclosed for the following purposes:

- **Treatment:** To provide, coordinate, or manage your healthcare services.
- **Payment:** To obtain payment for services we provide to you, including submitting claims to your health insurance provider.
- **Healthcare Operations:** For administrative purposes, such as quality improvement, audits, and training.

We may also disclose your health information without your consent or authorization in certain situations, including:

- **Public Health Activities** (e.g., reporting disease outbreaks).
- **Law Enforcement** and **Court Orders** (e.g., if required by law or in response to a court order).
- **Health Oversight Activities** (e.g., audits by insurance companies or government agencies).

Your Rights Under HIPAA:

You have the following rights with respect to your health information:

- **Right to Inspect and Copy**: You may request to see or get a copy of your health records.
- **Right to Request Corrections**: If you believe any information in your record is incorrect, you can request a correction.
- **Right to Request Restrictions**: You can ask that we restrict how we use or share your information.
- **Right to Confidential Communications**: You can request that we contact you in a specific way (e.g., by mail or phone).
- **Right to Receive a Copy of This Notice**: You have the right to receive a copy of this **Notice of Privacy Practices**.

Acknowledgment of Receipt

By signing below, you acknowledge that you have received a copy of the **Notice of Privacy Practices** from **Abide Health Medical**. You understand that this notice explains how your health information may be used and disclosed, and what your rights are regarding your health information.

If you do not wish to acknowledge receipt of this notice, please inform our staff and we will make a note of your preference in your medical records.

Patient Acknowledgment:

I, the undersigned, acknowledge that I have received and reviewed the **Notice of Privacy Practices** from **Abide Health Medical** and understand how my health information may be used and disclosed. I understand that I can request a copy of this notice at any time.

Patient Name (Printed): _____

Patient Signature: _____ **Date:** ___ / ___ / _____