Atlantic Internal Medicine

Notice of Privacy Practices Acknowledgement and Consent

PATIENT'S NAME	DATE	PATIENT'S DATE OF BIRTH

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

I understand that, under the Health Insurance Portability and 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 payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have had the opportunity to understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 at the address below 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 healthcare 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.

SIGNATURE	RELATIONSHIP TO PATIENT

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

DATE	INITIALS	REASON

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Patients 18 and over must complete the following:

I hereby authorized Atlantic Internal Medicine, PLLC to use or disclose the following:

❑ All Protected Healthcare ❑ Other _____

My protected health information may be disclosed to:

(List all names) _____

This protected health information is being used or disclosed to provide healthcare.

This authorization shall be in force and effective until:

❑ Enter date of expiration: _____

I understand that, as set forth in Atlantic Internal Medicine's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to: complianceoffice@aimhealthofva.com

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or Virginia Law).
- Refuse to sign this authorization.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE	DATE