

PATIENT ACKNOWLEDGEMENT FORM

Patient Acknowledgement of Understanding of North Macon Family Healthcare Associates Privacy Practices

Patient's name: _____ Date of Birth _____

SSN: _____

I understand that the patient's health information is private and confidential. I understand that North Macon Family Healthcare Associates works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand the North Macon Family Healthcare Associates 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 more example would be if a patient threatened to hurt someone.

North Macon Family Healthcare Associates has a detailed document call the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is available to me upon request. I understand that I have the right to read the "Notice of Privacy Practices" before signing this Acknowledgement.

North Macon Family Healthcare Associates may update this Acknowledgement and "Notice of Privacy Practices". If I ask, North Macon Family Healthcare Associates will provide me with the most current "Notice of Privacy Practices".

Within this "Notice of Privacy Practices" is contained 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 and accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

North Macon Family Healthcare Associates has established procedures which help them meet their obligations to patients. These procedures may include signature requirements, written acknowledgements, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist North Macon Family Healthcare Associates by following these procedures if I choose to exercise any of my rights described in the "Notice or Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of the North Macon Family Healthcare Associates "Notice of Privacy Practices".

Date

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