



**Notice of Privacy Practices Acknowledgement**

Under the Health Insurance Portability and accountability Act (HIPAA) of 1996 you the patient have certain rights to privacy regarding your protected health information (PHI). This information can be disclosed to other entities for the purposes of:

1. **Treatment:** The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consulting between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.
2. **Payment:** Reimbursement for the provision of healthcare, which includes but is not limited to: Billings, claims management, collection activities, obtaining payment under a contract for reinsurance, and related health care data processing.
3. **Health care operations:** Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, (provided that the obtaining of generalized knowledge is not the primary purpose of any studies resulting from such activities); population-based activities relating to improving health or reducing health care costs, protocol development, case management, and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment.

I have received, read and understand MGNC/SDCC’s full and complete version of its *Notice of Privacy Practices*. I understand that I may request: restrictions on disclosures, a history of non-routine disclosures, access to your medical records and that my protected health information be amended. However, MGNC/SDCC does not have to agree to the requested restriction but if we do we are bound to abide by them. In addition, MGNC/SDCC does not have to grant access to or amend your medical record if it is not in your best interest as determined by your physician.

Patient Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**OFFICE USE ONLY**

I attempted to secure the patient’s signature in acknowledgement of this Notice of Privacy Practices but was unable to do so.

Reason for not signing \_\_\_\_\_

Date: \_\_\_\_\_ Initials \_\_\_\_\_