Collin County Pulmonary Associates
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Twin Creeks Medical, Bldg 2
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NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPAA), I have certain rights to privacy regarding my medical records or 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 payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I understand that Collin County Pulmonary Associates can change this Notice of Privacy Practices and that I may obtain a currant copy of the Notice of Privacy Practices at any time.

_____ Initial here if you want a copy of our Notice of Privacy Practices for your personal home records.

I understand that I may request in writing that you restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care options. 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. I understand that unless I have made written restrictions you will proceed as though there are none.

_____ Initial here if you have provided us in compliance with HIPPA with a record of disclosures form with specific restrictions on how your protected health information is used or disclosed.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (*printed):* _____

Signature: _____

Relationship if other than patient: _____

Date: _____

OFFICE USE ONLY

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

Date:	Initials:	Reason:

☐ Notice of Privacy Practices given to patient as requested above ☐ Records of disclosure form received from patient and placed in chart☐ Individual patient medical record updated with above