SUBMIT FORM

PLEASE FILL IN THE FORM AND SEND IT BY CLICKING **SUBMIT FORM** IN THE UPPER RIGHT

OR SIGN AND RETURN BY FAX TO: (925) 901-0199

Acknowledgement of Receipt of Privacy Policy Notice

This document acknowledges that you have received a copy of the Notice of Privacy Practices. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

I, _____ (Patient),
Acknowledge that I have received a copy of the Notice of Privacy Practices.

_____

Patient's Signature Date

If the patient is a minor, a parent or legal guardian must sign.

_____

Parent or legal Guardian Date

_____

Relationship to Patient

If the patient is NOT a minor, but under the care of a friend, relative, or caregiver, sign here.

_____

Signature Date

_____

Relationship to Patient

Notice of Policy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment and for healthcare operations.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances:

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency
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For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected healthcare information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.
- You have the right to request an alternate means or location to receive communications regarding your health information.

- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.
- You have the right to request in writing to restrict some uses and disclosures of your health information.
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.

Changes to this Notice: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, and updated notice will be posted and a copy will be made available to you.