Internal Medicine Specialists, P.C.

PATIENT ACKNOWLEDGEMENT FORM

Patient Acknowledgement of Understanding of Internal Medicine Specialists, P.C.'s Privacy Practices

Patient's Name: _____ Date of Birth: _____

SSN: _____ Previous Name: _____

I understand that the patient's health information is private and confidential. I understand that Internal Medicine Specialists, P.C. (IMS), works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information. I understand that IMS 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. I understand that sometimes the law may require the release of information without my permission. These situations are very unusual. Examples would be if a patient threatened to hurt someone or the legally required reporting of certain diseases.

IMS has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement. IMS may update this "Notice of Privacy Practices" at any time and without notice to me. A copy of the revised "Notice of Privacy Practices" may be requested in writing addressed to the Privacy Officer at the office of IMS.

With this consent, IMS may call my home or other alternative location and leave a message on voice mail, answering machine or in person in reference to any items that assist the practice in carrying out treatment, payment or health care operations (TPO), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including, but not limited to, laboratory or other test results. With this consent, IMS may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, test results and patient statements.

Under the terms of this consent, I can ask IMS to limit how the patient's personal health information is used or disclosed to carry out TPO. I understand that IMS does not have to agree to my request. If IMS does agree to my request, I understand that IMS would follow the agreed limits. Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my records, restrictions on certain uses, and receiving an accounting of disclosures as required by law.

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

I may cancel this consent in writing at any time by doing the following: Writing, signing, and dating a letter to the Privacy Officer at IMS. This letter must include the patient's name, address, social security number and birth date. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the patient's personal health information for treatment, payment, and health care operations. I understand that information released prior to my canceling my consent is not covered by this cancellation. If I do not sign this consent, or later revoke this consent, IMS does not have to provide any further health care services to the patient.

My signature below indicates that I have been given the chance to review a current copy of IMS "Notice of Privacy Practices". My signature means that I agree to allow IMS to use and disclose the patient's personal health information to carry out treatment, payment, and health care operations and for other disclosures as outlined in the "Notice of Privacy Practices".

_____
Print Name

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____
Relationship to patient, if signed by anyone other than the patient (parent, legal guardian, personal representative, etc).