MedCare
Notice of Privacy Practices Acknowledgement

Patient Acknowledgement of Understanding of Healthcare Practice Management, LLC (D/B/A MedCare)

Patient Name: _____ Date of Birth: _____

I understand that the patient's health information is private and confidential. I understand that MedCare works very hard to protect the patient's privacy and preserves the confidentiality of the patient's personal health information.

I understand that MedCare 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.

MedCare has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting the privacy and is attached to this Acknowledgement. I understand that I have the right to read the "Notice" before signing this acknowledgement.

MedCare may update this Acknowledgment and "Notice of Privacy Practice". If I ask, MedCare 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 an accounting of disclosures as required by law; and requesting communication by specified methods of communications or alternate location.

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

My signature below indicates that I have been given the chance to review a current copy of MedCare's "Notice of Privacy Practices".

_____ _____
Patient or legally authorized individual signature Date

_____
Relationship to patient

Refusal to sign acknowledgement: _____ _____
MedCare Witness Date
(Please print full name)