INTEGRATED CARE
DIRECT ACCESS • PATIENT CENTERED

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA)

We want to inform you of the rights you have as a patient under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Under HIPAA, I understand that my personal information may be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in my treatment directly or indirectly
- Obtain payment from third-party payers for my healthcare services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of Integrated Care's Notice of Privacy Practices and understand that I may request a copy of this Notice for my own use. I understand that Integrated Care, Inc. has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I further understand that Integrated Care is not required to accept my requested restrictions, but if they are accepted then I understand that Integrated Care will honor my request unless it is an emergency.

I further understand that I have the right to not sign this acknowledgment in order to receive treatment at Integrated Care.

Authorization to Communicate Protected Health Information - Check all that apply:

- ❏ Integrated Care may leave a detailed message on voicemail at my home #: (_____) _____
- ❏ Integrated Care may leave a detailed message on voicemail at my cell #: (_____) _____
- ❏ Integrated Care may speak with another person (spouse, family member) about my medical condition:
  - ❏ **Including**/ ❏ **excluding** information related to:
  - ❏ mental/behavioral health _____ Initial
  - ❏ substance abuse _____ Initial
  - ❏ sexually transmitted disease and reproductive medicine _____ Initial
  - ❏ HIV status _____ Initial

Information may be released to:

Name/Relation: _____ Phone #: (_____) _____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify Integrated Care should I change one or more of the telephone numbers listed above.

_____ /_____ _____ / _____

Signature Today's Date Patient Name Date of Birth

_____ _____

Parent or Guardian Name Relation to Patient