Acknowledgement of Notice of Health Information Practices

We have made available to you our Notice of Health Information Practices. PLEASE REVIEW THIS NOTICE CAREFULLY! You may have a personal copy of the Notice, or you may access the Notice on-line at cchs.ua.edu/department/UMC.

The Notice explains when we might use/disclose your health information, and includes some of the following examples:

- when you give us permission to disclose your health information
- to aid in your treatment
- to help us or other health care providers get paid for services provided to you
- to improve our health care operations
- for use by businesses with whom we contract to help provide administrative support, but only if they agree in writing to keep your information private
- to persons involved in your health care or the payment for your health care
- to public health agencies, governmental agencies, or other entities or persons when required or authorized by law or when required or permitted to do so by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Notice also explains some of your rights under HIPAA, including but not limited to your:

- right to ask that information about you not be disclosed to certain persons
- right to ask that we communicate differently with you to ensure your privacy
- right to look at and get a copy of most of your health information in our records
- right to request that we correct health information in your record that is wrong or misleading
- right to have us tell you to whom we have disclosed your health information
- right to make a complaint with our Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

I acknowledge that I have been given an opportunity to review this facility’s Notice of Health Information Practices, that I understand what kind of information is contained in the Notice, that I am entitled to have my own personal copy of the Notice, and that a copy is available for me to have.

Signature of patient or patient’s representative: __________________________ Date: __________

Printed Name of patient’s representative: __________________________

Relationship to the patient/description of authority to act for patient: __________________________

FOR UMC USE ONLY:
Date Notice Made Available: ________ Notice Delivered: in person, mail, electronic Acknowledgement Signed? __ Yes, __ No
Why Acknowledgement Not Signed: __ patient refused __ patient failed to return __ emergency __ other

Signed copy of Acknowledgement should be filed in Patient’s Record