NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

MIDWEST HEALTH CENTER P.C.
1101 E 7TH ST
ATLANTIC, IA 50022
712-243-5790

I understand that, under the Health Insurance Portability and Accountability Ace of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Midwest Health Center P.C. has the right to change its Notice of Privacy Practices from time to time and that I may contact Midwest Health Center P.C. at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

Patient name (Please Print): _____

Signature: _____

Relationship to Patient (Circle one): Self Parent Legal Guardian Other:_____

Date: _____ **Witness/Staff:** _____

I attempted to obtain the patient's signature, but was unable to do so as documented below:

Date: _____ Staff Initials: _____

Reason:

_____

_____