PATIENT ACKNOWLEDGEMENT FORM

Patient Acknowledgement of Understanding of Dr. Felder's Privacy Practices

Patient's Name:_____ Date of Birth:_____

Member ID:_____ Previous Name:_____

I understand that the patient's health information is private and confidential. I understand that Dr. Virginia Felder works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Dr. Felder 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 unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

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

Dr. Felder may update this Acknowledgement and "Notice of Privacy Practices". If I ask, Dr. Felder will provide me with the most current "Notice of Privacy Practices".

Within this "Notice of Privacy Practices" is contained a complete descriptions of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications.

Dr. Felder has established procedures which help them 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 Dr. Felder by following these procedures if I choose to exercise any of the 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 Dr. Felder's "Notice of Privacy Practices".

_____ _____ _____

Signature Date Time

_____

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