ACKNOWLEDGEMENT OF PRIVACY PRACTICES

AA15.PT.FRM

You may refuse to sign this acknowledgement & authorization. By refusing we *may not be allowed* to process your insurance claims.

The Health Insurance Portability and Accountability Act ("HIPAA") requires us to provide you with notice of our privacy practices. The privacy notice includes our policies on reviewing, amending and/or copying your protected health information (PHI).

Our goal is to protect your privacy, and we encourage you to read the notice of our privacy practices.

The undersigned acknowledges review of and was offered a copy of the currently effective Notice of Privacy Practices

Version Number/Date V03 2014-10-15 for this healthcare facility. A copy of this signed and dated document shall be as effective as the original. By signing this Patient Privacy Acknowledgement Form, you acknowledge and authorize, that this healthcare provider may recommend products or services to promote your improved health. This healthcare provider may or may not receive third party remuneration from these affiliated entities. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Adelante may contact me about special services, events, fund raising or new health information or services. If I wish to opt out of these communications – I need to notify the Privacy Officer by mail at 9520 W Palm Lane, AZ 85037 or email at privacyofficer@adelantehelathcare.com

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS / FACILITIES IN THE FUTURE.

Patient Signature Date of Birth

Date

Please Print Name

Parent or Guardian Signature Consent
(If under the age of 18 years old)

Legal Representative [if applicable]

Description of Authority

Your comments or special requests regarding Acknowledgements or Consents:

Staff: Send copy to Patient Portal