Mark Leventer, MD

Patty Hopkins, CNP

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act 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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain authorization and payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments.

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 this organization has the right to change its Notices of Privacy Practices from time to time and that I may contact the organization at any time at the address below 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 also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name (printed): _____

Relationship to Patient (check one): Self____ Parent____ Legal Guardian____

Signature: _____

Date: _____

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OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

Grass Lake Medical Center
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