CITRUS PULMONARY CONSULTANTS AND SLEEP DISORDERS CENTER
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient's name: _____ Date of birth: _____

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

I understand that Citrus Pulmonary Consultants may use and disclose the patient's personal health information to help provide care to the patient, to handle billing and payment, and to take care of other health care operations.

Citrus Pulmonary Consultants 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 Acknowledgment. I understand that I have the right to read the ***Notice*** before signing this Acknowledgment.

Citrus Pulmonary Consultants may update this Acknowledgment and ***Notice of Privacy Practices.*** Citrus Pulmonary Consultants will provide me with the most current ***Notice of Privacy Practices.***

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't 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 or alternative location.

Citrus Pulmonary Consultants 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 Citrus Pulmonary Consultants by following these procedures if I choose to exercise any of my rights described in the ***Notice of Privacy Practices.***

Restrictions:
I request the following restrictions to the use of disclosure of my health information:

_____

_____

Please tell us with whom we may discuss your treatment, payment or healthcare operation:
Example: spouse (name), children (names), other relatives (names), and friends or caregivers (names)

_____

_____

_____

_____

Messages or Appointment Reminders:
May we leave a message at your <u>home</u> using doctor's/practice name: ❑ Yes ❑ No

May we leave a message at your <u>work</u> using doctor's/practice name: ❑ Yes ❑ No

Do not leave a message: ❑ Yes ❑ No

My signature below indicates that I have been given the chance to review a current copy of Citrus Pulmonary Consultants' ***Notice of Privacy Practices.***

_____ _____
Signature Date