Assurance
Healthcare & Counseling Center

Acknowledgement of Privacy Practices (HIPAA)

We want to inform you of the rights you have as a patient under the Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Under HIPAA, I understand that my personal information may be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of Assurance Healthcare & Counseling Center's (AHCC) Notice of Privacy Practices and understand that I may request a copy of this Notice for my own use. I understand that Assurance Healthcare & Counseling Center has the right to change the Notice of Privacy Practices and that I may contact this office 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 healthcare operations. I further understand that AHCC is not required to accept my requested restrictions, but if they are accepted than I understand that AHCC will honor my request unless it is an emergency.

I further understand that I have the right to not sign this acknowledgment in order to receive treatment at AHCC.

Authorization to Communicate Protected Health Information – check all that apply:

☐ Assurance may leave a detailed message on voicemail at my home #: (_____) _____-_____

☐ Assurance may leave a detailed message on voicemail at my cell #: (_____) _____-_____

☐ Assurance may speak with another person (spouse, family member) about may medical condition
☐ including /

☐excluding information related to mental health, sexually transmitted disease, HIV status and reproductive medicine:

Name/Relationship: _____ phone#: (_____) _____-_____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify AHCC should I change one or more of the telephone numbers listed above.

_____	_____	_____/_____/_____
Signature	Patient (printed) name	Date of birth
_____	_____	_____/_____/_____
Representative Name	Relationship to Patient	Today's Date

For administrative use only:

We are unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

☐ Patient declined to sign ☐ Emergency situation ☐ communication barriers ☐other