**Blount Memorial** Hospital
907 East Lamar Alexander Parkway
Maryville, TN 37804-5016 865-983-7211

Place Patient

Label Here

## Acknowledgement of Notice of Privacy Practices

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 this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal health care operations such as quality assessments and physician certifications.

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 *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above 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 ______________________________
Please Print

RELATIONSHIP TO PATIENT ______________________________

SIGNATURE ______________________ DATE ______________

**OFFICE USE ONLY**

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

| Date | **Reason**<br>[ ] Emergency [ ] Patient refused<br>[ ] NOP Mailed to Patient and not returned<br>[ ] Other ______________________<br>______________________ |
|---|---|
| Initials | |

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