Institute
for Weight Management

Patient Name :_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR HEALTH INFORMATION RIGHTS

As a patient, you have the right to:

Request restrictions on certain uses and disclosures of your health information

Request to receive communications of health information by alternative means or at alternative locations

Inspect and copy your health information

Request amendment of your health information

Receive an accounting of disclosures of your health information

File a complaint with this office or with the Department of Health and Human Services

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We may use and disclose your health information for the following purposes:

Treatment: We may use your health information to provide you with medical treatment or services and may disclose your health information to other healthcare providers involved in your care.

Payment: We may use and disclose your health information to obtain payment for services we provide to you, including billing, claims management, and collection activities.

Healthcare Operations: We may use and disclose your health information for healthcare operations, including quality assessment, employee review, training, licensing, and conducting general administrative activities.

Other Uses and Disclosures: We may also use or disclose your health information:

When required by law

For public health activities

For health oversight activities

In response to court orders or lawful process

For law enforcement purposes when required

To prevent a serious threat to health or safety

For specialized government functions

For workers' compensation purposes

AUTHORIZATION FOR OTHER USES

Other uses and disclosures not described in this notice will be made only with your written authorization. You may revoke such authorization in writing at any time.

PATIENT CONSENT AND AGREEMENT

By signing below, I acknowledge that:

-I have received a copy of this practice's Notice of Privacy Practices

-I have been given the opportunity to ask questions about the Notice

-I understand my rights regarding my health information

-I consent to the use and disclosure of my health information for treatment, payment, and healthcare operations as described in the Notice of Privacy Practices

Signature: _____ Date: _____