

# RENAL MEDICAL ASSOCIATES, P.C.

## Notice of Privacy Practices and Patient Acknowledgement (HIPAA)

Our Notice of Privacy Practices provides information about how we, as a healthcare practice, may use and dispose of protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our privacy Notice before signing this consent. We have our privacy policy posted within the lobby of our office and a copy is available to upon request. The terms of our notice may change. You may request a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations, unless otherwise restricted by your written request. You have the right to revoke this consent, in writing, at any time. However, such a revocation shall not affect any disclosures we have already made in reliance to your previous consent. Our practice provides this for to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Patient Understands that:

- Protected health information may be disclosed or used for treatment, pay, or health care operations.
- Our practice has a Notice of Privacy Practices and that the patient has to opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their information, but the practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of the Consent.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

\_\_\_\_\_  
Patient Signature or Patient Representative

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Printed Name – Patient or Patient Representative