HYPERTENSION & KIDNEY ASSOCIATES OF MIDDLE GEORGIA, LLC.
ACKNOWLEDGEMENT OF RECIEPT OF INFORMATION PRACTICES

The privacy of your health information is important to us this notice describes how your health information is used and disclosed and how you may access this information

OUR LEGAL DUTY:

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. This notice takes effect 09/01/2007 and will remain in effect until it's replaced

USES AND DISCLOSURES OF HEALTH INFORMATION

1. The practice may use and disclose protected health information for treatment, payment and healthcare operations. Treatment examples of these include, but are not limited to, referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims, including coordination of benefits with other insurers. Healthcare operations examples include internal quality control of records, etc.

2. The practice will not make, use or disclose, protected health information about the individuals written consent or authorization. Such authorization may be revoked at any time. Revocation must be in writing. Two exceptions to this would include public health requirements and court orders.

3. The practice reserves the right to change the terms of this notice and make new provisions effective for all the protected health information it maintains. The practice will provide each patient with a copy of any revisions of this notice at the time of the next visit, or at the last known address. A copy can be obtained at the office at any time during business hours.

4. Any patient, guardian of personal representative has the right to:

    a. Object to the use of their health information for directory purposes.
    b. Inspect and obtain copies of the record.
    c. Request amendments be made to their record.
    d. Request a six-year accounting of all disclosures of the record. The history will be provided within 60 days and a reasonable charge maybe assessed.
    e. Request restrictions to how their information may be used or disclosed. The practice is not required to agree to these restrictions, but if the practice does agree, it must comply.

5. Any person or patient may file a complaint to the practice and to the secretary of Health and Human Services if they believe their privacy rights have been might violated. To file a complaint with the practice, please contact our office manager at the office or phone number. All complaints will be addressed and the results will be reported. It is the policy of the practice that no retaliatory action will be made against any individual who submits a complaint.

CONSENT TO USE AND DISCLOSURE

I ______________________________ have had the opportunity to read the notice and consent to the use and disclosure of my protected information to carry out treatment, payment activities and healthcare operations. Name of patient date signature relationship to patient

NAME OF PATIENT______________________________ **DATE**______________________

SIGNATURE ______________________________ **RELATION TO PATIENT**______________