PATIENT ACKNOWLEDGMENT FORM

Patient Acknowledgment of Understanding of McDuffie Medical Associates, P.C. Privacy Practices

Patient's name: _____ Date of birth: ____/____/____ SSN: ____/____/____

I understand that the patient's health information is private and confidential. I understand that McDuffie Medical Associates, P.C. works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information (PHI).

I understand that McDuffie Medical Associates, P.C. may use and disclose the patient's (PHI) to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

McDuffie Medical Associates, P.C. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgment. I can find this document in the lobby at McDuffie Medical Associates and if I ask I will receive the most current "Notice of Privacy Practices". McDuffie Medical Associates, P.C. may update this Acknowledgment and "Notice of Privacy Practices".

I will assist McDuffie Medical Associates, P.C. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices". My signature below indicates that I have been given the chance to review a current copy of McDuffie Medical Associates, P.C., "Notice of Privacy Practices".

I understand that McDuffie Medical Associates will provide PHI to anyone involved in my treatment. In addition, I give McDuffie Medical Associates, P.C. authorization to release my PHI to those listed below that may or may not be involved in my treatment.

Name	Relationship	Phone Number
1._____		
2._____		
3._____		

Emergency Contact: _____ _____ _____

Name **Relationship** **Phone Number**

Ethnic Group (circle one): White African American American Indian/Alaska Native Hispanic or Latino Asian

Race (circle one): White African American American Indian/Alaska Native Hispanic or Latino Asian

Chinese Filipino Japanese Multiracial Native American Pacific Islander Other: _____

Primary Language (circle one): English Spanish Other: _____

Please provide us with your email address
For future access to our patient portal: _____@_____._____

_____ _____

Signature Date

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc)