**CARENET MEDICAL GROUP**

2123 River Road, Schenectady, New York 12309 (518) 381-1121 ϖ (518) 381-3930 (Fax)
2 Chelsea Place, Clifton Park, New York 12065

# NOTICE OF PATIENT PRIVACY PRACTICES ACKNOWLEDGEMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines the conditions under which we may use and disclose your protected health information. This law also provides you certain rights that are designed to protect your privacy. Your rights and circumstances under which we may use your protected health information are outlined in our Notice of Privacy Practices. We request that you acknowledge having received a copy of our notice by signing below.

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Please provide us with your preferred method that we may communicate your PROTECTED HEALTH INFORMATION (PHI).

1. Are you a FOLLOW MY HEALTH PATIENT? _____Yes _____No. If YES, you will receive all of your appointment reminders, NORMAL test results, etc… from your Portal Account. **If you are NOT a FOLLOW MY HEALTH PATIENT, and wish to become one, please let us know today.**

2. If you have chosen NOT to use our PATIENT PORTAL, please direct us how you would like to be notified in the future:

May we leave a message regarding your PHI on your answering machine? _____Yes _____No

_____ I do **not** wish to share my PHI with anyone at this time. I do understand that I have the right to change my mind at anytime. I understand that if I choose to change this information it must be done in writing.

_____ I do wish to share my PHI. Please provide us with the names of those individuals who are involved in your care in which you give permission to us so that we may share your protected health information to coordinate your care.

________________________________________ ______________________________
Name of individual involved in your care Relationship to you

________________________________________ ______________________________
Name of individual involved in your care Relationship to you

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I acknowledge that the information I have provided is honest and true to the best of my ability. I have also been made aware that a mandatory identity theft policy, requiring a copy of a photo ID be attached to my personal information, has been implemented at the CareNet Medical Group offices. CareNet Medical Group does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment.

________________________________________ ______________________________
Signature of patient or authorized representative Date

________________________________________ ______________________________
Print Name of patient or authorized representative Date

**MEDICAL RECORDS #:** ______________________