Capital Medical Clinic

4701 Normal Blvd Lincoln, NE 68506

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE

To our patients:
The privacy of your healthcare information is extremely important to us. We want you to understand how we use and disclose your information and your rights in this information. We ask you to review our notice of Privacy Practices that describes our legal duties with respect to your healthcare information.

How we use healthcare information:
In summary, we may use information to:

- Provide treatment to you
- Ensure appropriate payment for the treatment we provide; and
- Monitor the quality of our operations

When we may disclose information:
Under certain limited cases, we are permitted to disclose healthcare information about you. Examples include when there is a serious threat to health or safety, for workers' compensation, to reduce public health risks, for health oversight, and in certain cases for law enforcement. In addition, we may disclose information to tell you about health-related services and alternative treatments and to conduct health related research with your permission.

Your information rights:
We create a record of the care we give you. You have the following rights to this information:

- You have the right to know how we use your health information, who we give it to, and your rights to this information. Please refer to our Notice of Privacy Practices.
- You have the right to ask us to restrict uses and disclosures where we believe such restrictions will not harm you and where it is possible for us to do so.
- You have the right to confidential communication of your health information. For example, you can ask for a conversation to be held in private, or for us to send a copy of your bill to a different address.
- You have the right to look at and get a copy of information in your record, known as "designated record set", unless your doctor has indicated this would be harmful to you or someone else.
- You have the right to request that your records be amended if we agree it is inaccurate or incomplete.
- You have the right to ask us for a list when we have disclosed your health information to someone other than those treating you, handling your bills, for our internal operations, or when you have authorized release of information.
- Please sign below that you have received our Notice of Privacy Practices. If you have any questions, please speak to your physician or our Privacy Officer.

Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

For Office Use Only

Received by: _____Date_____

____ Patient received NPP but refused to sign acknowledgement form.
____ Patient was offered NPP and refused to sign it, as well as refused to sign acknowledgement form.

Signature of Employee: _____Date: _____

Revised 05/2014)