Your Medicos S.C.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of-1996 (HIPAA), I have rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certification.

I received, read and understand your Notice of Privacy Practices containing a complete information about the uses and disclosures of my health information. I understand that this organization has rights to change its Notice of Privacy Practices from time to time and that I may contact anytime at the addresses above to obtain a current copy of the Notice of Privacy Practice. I understand that may request in writing that you restrict how my private information is used or disclosed out treatment, payment, or healthcare operations. I also understand you are not required to agree or requested restrictions, but if do agree then you are bound to abide by such restriction.

Patient Name: _____

Relationship to Patient : _____

Signature: _____

OFFICE USE ONLY

Implemented to obtain the patient's signature in acknowledgment of this Notice of Privacy acknowledgment, but was unable to do so as documented below.

Initials: _____ Reason: _____