Beaches Acupuncture & Wellness Center

# Acknowledgement of Receipt of Notice Of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

**How we may use and share health data about you.**
a) Treatment - to give you medical treatment or other types of health services.
b) Payment - to bill you or third party for payment for services provided you.
c) Health Care Operators - for our own operations: quality control, compliance monitoring, audit, etc.

**Disclosures where you are not given an opportunity to agree or object:**
a) To you.
b) If child abuse or neglect is suspected.
c) As required by Federal, State or Local Law.
d) Public health risks (for public health activities to prevent and control the spread of disease.)
e) Lawsuit and disputes (in response to a court or administrative order.)
f) Law enforcement (to help law enforcement officials respond to criminal activities.)
g) Coroners, medical examiners and funeral directors.
h) Organ or tissue donation facilities if you are an organ donor.
i) To avert a threat to an individual or to public health safety.

**Disclosures where we must give you a chance to agree or object:**
a) Patient directories - you can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care - we may share your health data with a family member, or a close friend, or other persons that you have named as being involved with your health care.

**Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.**

**You have the following rights relating to the health data we keep about you:**
a) To inspect your health record and to receive a copy of it upon request.
b) To amend information in your health record that you believe is inaccurate or incomplete.
c) To know to whom we have disclosed your health information.
d) To ask for limits on the health information data we give out about you.
e) To receive communication from us about your health information in alternate ways.
f) To a paper copy of the complete Notice Of Privacy Practices.

I, the undersigned, acknowledge that I have received the NOTICE OF PRIVACY PRACTICES for this practice and/or may review it online at: www.jaxbeachacu.com

_____ _____
Signature of Patient or Representative Date

_____ _____
Print Patient Name DOB