



**MOUNTAIN  
HEALTH**

Mountain Health & Community Services, Inc.

**Notice of Privacy Policies Acknowledgement**

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

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

I acknowledge that I have received a copy of Mountain Health & Community Services, Inc. (MHCS), Privacy Practices containing a more complete description of the uses and disclosures of my health information, and I consent to the use of my **Protected Health Information (PHI)** for treatment, payment, and healthcare operations of the practice.

I understand that this organization has the right to change its notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the notice of Privacy Practices.

I understand that I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment, and health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**\*\*If you would like a copy of our HIPAA Privacy Practices please let the receptionist know.\*\***

**FOR OFFICE USE ONLY:**

**I attempted to obtain the patient's signature regarding MHCS' Notice of Privacy Practices Acknowledgement, but was unable to do so as documents below:**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Member Signature

Reason: \_\_\_\_\_

\_\_\_\_\_