Neurology Consultants of Kansas
Acknowledgement of Privacy Practices and Disclosure Preferences

Patient Name_____Date of Birth_____Date_____

Signature_____

I acknowledge that I have received notice of this clinic's privacy practices and do hereby give authorization for this clinic to verbally release any or all medical information concerning my medical/physical condition, test results, and treatment to the following family/friends:

Name/Relationship Name/Relationship

_____ _____
_____ _____
_____ _____

Notice of Privacy Practices

We understand that medical information about you is personal. We are committed to protecting medical information about you. Clinic employees are committed to protecting your personal health information and privacy. We will use your information to provide you care and treatment, create a record of the care and services you receive, bill your insurance in a timely manner, and operate our facility in a diligent manner. We will safeguard your information and share it only with those who need or are entitled to know. We will obtain your permission for other use or disclosure. You may ask to see, change, restrict, or obtain a copy of your information and file a formal complaint if we fail to assure your privacy or information confidentiality. For more details, please read this Notice of Privacy Practices.

Notice of Privacy Practices (If you have any questions, please contact our Administrator)
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This clinic provides health care to our patients in partnership with physicians and other professionals and organizations involved in your care. Our Privacy Practices Guide:
*Any health care professional who treats you at any of our locations *All departments and units of our organization, including all off-campus units or departments *All staff or volunteers of our organization *Any business associate or partner of this clinic with whom we need to share your health information.

We are required by law to:
*Keep medical information about you private *Provide you this notice of our legal duties and privacy practices with respect to medical information about you *Follow the most stringent state or federal law *Abide by our currently published Notice of Privacy Practices.

We may change our policies at any time. Changes will apply to medical information we already have. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting area and exam rooms. You can receive a copy of the current notice at any time. You will be offered a copy of the current notice at the time of initial treatment. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose your medical information:
We may use and disclose medical information about you for treatment; to obtain payment for treatment; and to support our health care operations. We may use and disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight, audits or inspections, funeral

arrangements, organ donation, workers' compensation purposes and emergencies. We also disclose medical information when required by law, such as in response to valid judicial or administrative orders. *We may also contact you for appointment reminders or to tell you about recommended possible treatment options, alternatives, health-related benefits or services that may be of interest to you. *We may disclose medical information about you to a friend or family member who is involved in your care or to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of medical information:
*In any other situation not involving routine care, financial and insurance matters or hospital operations, we will ask for your written permission before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding medical information about you:
*In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care, after you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision. If you believe that information in your records is incorrect or if important information is missing, you have the right to request that we correct the records by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to correct or amend the record if the information was not created by us; if it is not part of the medical information maintained by us; or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record. *You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, healthcare operations, or where you specifically authorized a disclosure. The written request must state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs. *If this notice was sent to you electronically, you have the right to a paper copy of this notice. *You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you. *You may request, in writing, that we not use or disclose medical information about you for treatment, payment or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request, but we are not legally required to accept it. We will inform you of our decision on your request.

All written requests or appeals should be submitted to the Neurology Consultants of Kansas Privacy Office.

Complaints
*If you wish to file a complaint because you feel that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office (listed below). *Finally you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. *Under no circumstance will you be penalized or retaliated against for filing a complaint.

Neurology Consultants of Kansas Privacy Office
2135 N. Collective Lane
Wichita, KS 67206
316-261-3220

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, SW
Washington, DC 20201

If you desire a copy of this document for your own records, please request one at time of check – in.