RESPIRATORY CONSULTANTS OF GEORGIA

Suzette A. Chin, MD FCCP
Timothy Lin, MD FCCP
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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & 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 may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my information. 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 at the address above to obtain a current copy of the *Notice of Privacy Practices.*

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

On occasion, it may be necessary to release clinical information to outside physicians, radiological institutions, laboratories or physical therapy centers that you have been referred to, to aide in your coordination of care. We will not release your information to any third parties.

Designation of Certain Relatives, Close friends and other caregivers as my Personal Representative:

I agree that the practice may disclose certain pieces of my health Information to a Personal Representative of my choosing, since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practices will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my health care.

Print Name: ______________________________ Phone Number:________________
Print Name: ______________________________ Phone Number:________________
Print Name: ______________________________ Phone Number:________________

The following person(s) ARE NOT AUTHORIZED to receive my Patient Health Information (PHI):
Print Name: ______________________________
Print Name:______________________________

__________________________________ ____________________
Patient Name Date

____
Relationship to Patient (if not self)

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