Stillwater Primary Care

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

- I have reviewed/received a copy of the Stillwater Primary Care's "Notice of Privacy Practices".

- I understand that Stillwater Primary Care employs my provider along with all other staff. I understand that Stillwater Primary Care owns and maintains my medical record and, in its "Notice of Privacy Practices" has assured me that my medical record is kept confidential as required by state and federal laws.

- I understand that if I wish to have access to my medical record or obtain copies of any information contained in my record, I can ask any employee of Stillwater Primary Care for assistance.

_____ _____

Signature of Patient DOB

_____ _____

Signature of Legal Guardian Date

Revised 09/30/2020

Stillwater Primary Care
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully. This notice will take effect on April 14, 2003 and will remain in effect until further notice.

Uses and Disclosures of Protected Health Information :

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that, relates to your past, present or future physical or mental health care services. You will be asked by our receptionist to sign acknowledgement of this information. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, the Physician and/or staff will use or disclose your protected health information as described below:
Your health information may be used and disclosed by your physician, our office and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the practice.

Your Health Information Rights:

Although your health record that was compiled by this facility is the physical property of the practitioner or facility, you are entitled to this information. You have the right to request a restriction on certain uses and disclosures of your information. This includes the right to obtain a paper copy of this notice as well as a paper copy of your health record. If you believe your rights have been violated, you have the right to file a complaint to the secretary of Health and Human Services. You may also file a complaint directly to this facility by obtaining a complaint form from the receptionist. We have 30 days to respond to your request. Due to the high cost of copying, there is a copying fee for medical records. All diagnostic testing results will not be disclosed by telephone.

Our Responsibilities:

This facility is required to maintain the privacy of your health information as well as providing you access to this notice of our privacy practices. We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. We will not use or disclose your health information without your authorization, except as described in this notice.

Examples of Disclosure of Your Record:

We may use your health information for the following:

Treatment, Payment, Our Business Associates, and Health Care Providers, Communication with Family, Research, Funeral Directors, Food & Drug Administration, and Worker's Compensation, Public Health, Law Enforcement and all others indicated in the Privacy Act.