PATIENT ACKNOWLEDGE FORM

PATIENT ACKNOWLEDGMENT OF UNDERSTANDING OF THE UNIVERSITY OF WEST GEORGIA'S "NOTICE OF PRIVACY PRACTICES."

Patient's name_____ **Date of birth**_____

SSN_____ **Previous Name**_____

I understand that the patient's health information is private and confidential. I understand that the University of West Georgia works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that the University of West Georgia may use and disclosed the patient's personal health care information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. (In general, there will be no other uses and disclosure of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.)

The University of West Georgia has a detailed document called the "Notice of Privacy Practices." The "notice of privacy practices" contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "notice" before signing this agreement.

The University of West Georgia may update this "notice of privacy practices." If I ask, the University of West Georgia will provide me with the most current "notice of privacy practices." Under these terms of this acknowledgment, I can ask the University of West Georgia to limit how the patient's personal health care information is used or disclosed to carry out treatment, payment or health care operations. I understand the University of West Georgia does not have to agree to my request. I understand the University of West Georgia would follow the agreed limits.

I may cancel this acknowledgment of consent in writing at any time by doing the following:
1. Signing and dating a form that the University of West Georgia can give me a form called "Revocation of Consent" for use and disclosure of health care information; or
2. Writing, signing and dating a letter to the University of West Georgia. If I write a letter, it must say that I want to revoke my acknowledgment of consent to authorize the use and disclosure of the patient's personal health care information for treatment, payment, and health care operations.

If I revoke this consent, the University of West Georgia does not have to provide any further health services to the patient.

My signature below indicates that I have been given the chance to review a current copy of the University of West Georgia's "Notice of privacy practices." My signature indicates that I have been given the opportunity to review a current copy of the University of West Georgia's "Notice of Privacy Practices" to use and disclose the patient's personal health care information to carry out treatment, payment, and health care information.

_____

Patient's or legally authorized individual signature **Date** **Time**

_____

Relationship to patient if signed by anyone other than the patient (Parent, legal guardian, personal representative, ECT).