Notice of Privacy Practices

383 Ocean Parkway
Brooklyn, New York 11218
718-941-6000

Parkway Pain Care & Rehabilitation

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I understand that as part of my health care, Parkway Pain Care & Rehabilitation, PC originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Parkway Pain Care & Rehabilitation, PC is not required to agree to the restrictions requested. I understand that I may revoke the consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations

I further understand that Parkway Pain Care and Rehabilitation, PC reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Parkway Pain Care & Rehabilitation, PC change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail, or if I agree, email). I wish to have the following restrictions to the use or disclosure of my health information.

_____

_____

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospital and facilities listed at the beginning of this Notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may separate written explanations of special privacy protections that apply to HIV-related information and mental health information.

Signature of Patient or Personal Representative _____ Date _____

Print Name of Patient or Personal Representative _____ Description of Personal Representative's Authority _____

CONTACT INFORMATION

The contact information of the patient or personal representative who signed this form should be filled in below.

Address: _____

_____

_____

Telephone Number: _____ _____

Daytime Evening

Email Address: _____

For Office Use Only

( ) Consent received by _____ on _____

( ) A good faith effort to obtain acknowledgement was made on _____

by _____

( ) Consent was refused by patient.

( ) Consent added to the patient's medical record on _____