HIPAA Notice of Privacy Practices & Acknowledgment

Patient acknowledgment of receipt and understanding

PATIENT INFORMATION

LAST NAME | **FIRST NAME** | **MIDDLE INITIAL**

DATE OF BIRTH | **SEX** | **SOCIAL SECURITY NUMBER (LAST 4)** | **PHONE**

MAILING ADDRESS | **CITY** | **STATE / ZIP**

EMAIL ADDRESS | **PREFERRED CONTACT METHOD**

How Ascribe Uses & Discloses Your Health Information

Ascribe Infusion Therapy is committed to protecting the privacy of your protected health information (PHI). The Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws give you specific rights regarding your health information. This form summarizes how we may use and disclose your information; the full **Notice of Privacy Practices** contains additional detail and is available at our front desk and on our website.

Routine uses and disclosures — without additional authorization, Ascribe may use or disclose your PHI for the following purposes:

- ☐ **Treatment.** Coordinating with your prescribing physician, sharing information with consulting clinicians, and providing safe care during your infusions.
- ☐ **Payment.** Verifying coverage, obtaining prior authorization, billing your health plan, and following up on claims.
- ☐ **Healthcare operations.** Quality improvement, medical record auditing, training, accreditation, and other internal administrative functions.
- ☐ **As required by law.** Reporting to public health authorities, responding to subpoenas, complying with FDA reporting requirements, and similar legal obligations.

Your Rights

- ☐ Receive a paper or electronic copy of our full Notice of Privacy Practices.
- ☐ Inspect and obtain a copy of your medical record (subject to limited exceptions).

- ☐ Request a correction or amendment to your record if you believe it is inaccurate.
- ☐ Request restrictions on certain uses and disclosures.
- ☐ Request that we communicate with you in a particular way (for example, by mail rather than phone).
- ☐ Receive an accounting of certain disclosures Ascribe has made of your PHI.
- ☐ File a complaint with Ascribe or with the U.S. Department of Health & Human Services if you believe your privacy rights have been violated. Filing a complaint will not affect the care you receive.

Acknowledgment

By signing below, I acknowledge that I have received or have been offered a copy of Ascribe Infusion Therapy's Notice of Privacy Practices and that I have had the opportunity to ask questions about how my health information will be used and disclosed.

- ☐ I have received the Notice of Privacy Practices.
- ☐ I have been offered the Notice but declined a copy at this time.

PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE SIGNATURE	PRINTED NAME	RELATIONSHIP TO PATIENT (IF NOT SELF)	DATE

Form code: ASC-HIPAA-001 · For staff use only: If the patient is unable or refuses to sign this acknowledgment, the staff member must document the reason and the date the Notice was offered in the patient's chart.