ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and CONSENT FORM

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in our Notice of Privacy Practices, updated effective September 23, 2013.

We are permitted to review our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Authorization of PHI Disclosure

The information described above may be disclosed to the following recipients:

- Name of Person #1: _____ Relationship to You: _____
- Name of Person #2: _____ Relationship to You: _____

I understand that MDSC will not condition treatment, payment, enrollment or eligibility for benefits on whether or not I sign this authorization form, except in the following situations:

- If the medical information to be disclosed will result from treatment for research purposes, MDSC will not provide the treatment if I am unwilling to sign this authorization form.

- If the information to be disclosed will result from treatment provided to me solely for the purpose of creating information to be disclosed to a third party, MDSC will not provide the treatment if I am unwilling to sign this authorization form.

Revocation of PHI Disclosure

I understand that I may revoke this authorization by completing a new *Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form*. I understand that I may not revoke this authorization during an insurance contestability period or with respect to disclosures that MDSC may have already made in reliance on this authorization. If I revoke this authorization, MDSC will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization. I understand that when MDSC discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

By signing below, I am acknowledging that I have received a copy of MDSC's Notice of Privacy Practices. I am also giving MDSC consent to disclose my protected health information to the person(s) listed above until such time a new *Acknowledgement of Receipt of Notice of Privacy Practices and Consent Form* is completed by me. I also understand and agree to the terms of this authorization.

Patient Name: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient: _____

_____

Signature: _____ Date: _____, 20____

To be completed by MDSC personnel if form is not signed:

I, _____, attempted to obtain the patient's acknowledgement of receipt of Notice of Privacy Practices, but was unable to do so.

Reason acknowledgement and consent not obtained: _____

Employee Signature: _____ Date: _____, 20_____