



**NOTICE OF PATIENT PRIVACY PRACTICES ACKNOWLEDGEMENT**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines the conditions under which we may use and disclose your protected health information. This law also provides you certain rights that are designed to protect your privacy. Your rights and circumstances under which we may use your protected health information are outlined in our Notice of Privacy Practices. We request that you acknowledge having received a copy of our notice by signing below.

In addition, we request that you provide us with direction regarding how we may communicate your protected health information by answering the following questions:

May we leave messages on your answering machine or with a member of your family who may answer the phone at home? \_\_\_\_Yes \_\_\_\_No

Please provide us with the names of those individuals who are involved in your care in which you give permission to us so that we may share your protected health information to coordinate your care.

\_\_\_\_\_  
Name of individual involved in your care Relationship to you

\_\_\_\_\_  
Name of individual involved in your care Relationship to you

May we have your email address? \_\_\_\_\_

Race: American Indian or Alaska Native Asian Black or African American Native Hawaiian  
White More than one race Other Pacific Islander Undefined

Ethnicity: Hispanic or Latino Non-Hispanic or Latino Declined to Report

Language: American Sign Language Arabic (Any) Chinese (Any) English German Other  
Russian Spanish

\_\_\_\_\_ I do not wish to share my health information with anyone at this time. I do understand that I have the right to change my mind at anytime. I understand that if I choose to change this information it must be done in writing.

I acknowledge that the information I have provided is honest and true to the best of my ability. I have also been made aware that a mandatory identity theft policy, requiring a copy of a photo ID be attached to my personal information, has been implemented at CareNet Medical Group. CareNet Medical Group does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment.

\_\_\_\_\_  
Signature of patient or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of patient or authorized representative

\_\_\_\_\_  
Date



**CARENET  
MEDICAL  
GROUP**

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2 Chelsea Place, Clifton Park, New York 12065

**MEDICAL RECORDS #:** \_\_\_\_\_