

**ALASKA MEDICAL
CLINICS,
LLC**



Dimond Medical Clinic	Wasilla Medical Clinic	Lake Otis Medical Clinic
300 East Dimond Blvd., #12, Anchorage, AK 99515 907-341-7757	1700 E. Parks Hwy., #200, Wasilla, AK 99654 907-373-6055	4001 Lake Otis Parkway, #100 Anchorage, AK 99508 907-561-7757

NOTICE OF PRIVACY, CONSENT, AND HIPPA

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Release for Protected Health Information:

Indicate any persons authorized to discuss your Protected Health Information with our office or our billing office. Include the person's name and relationship to yourself. Include a start date and an end date to set restrictions for any individual(s).

Name	Relationship	Start Date	End Date
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name _____

Patient Signature _____ Date _____

Parent Signature if Minor Child _____ Date _____

Office Use Only:

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practice Acknowledgement, but was unable to do so as documented below:

Date: _____ **Initials:** _____ **Reasons:** _____