

**COLUMBUS CLINIC**  
**PATIENT ACKNOWLEDGMENT FORM**

Patient Acknowledgment of Understanding The Columbus Clinic's Privacy Practices

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Previous name: \_\_\_\_\_

I understand that the patient's health information is private and confidential. I understand that The Columbus Clinic works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that The Columbus Clinic may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. ( In general, there will be no other uses and disclosures of this information unless I permit it.I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.)

The Columbus Clinic has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the " Notice" before signing this Acknowledgment.

The Columbus Clinic may update this Acknowledgment and " Notice of Privacy Practices". If I ask, The Columbus Clinic will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

The Columbus Clinic has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments , and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist The Columbus Clinic by following these procedures if I choose to exercise any of my rights described in the " Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of The Columbus Clinic's "Notice of Privacy".

\_\_\_\_\_  
Patient or legally authorized individual signature      Date      Time

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Relationship to patient if signed by anyone other than the patient (parent, legal guardian)