

CANYON MEDICAL CENTER SUMMARY OF PRIVACY NOTICE
08/12/04

The information contained in this summary is **NOT** a comprehensive explanation of the mandated HIPAA privacy notice. It is meant to assist patients with an additional understanding of the privacy policies of Canyon Medical Center, Inc. Signing the acknowledgement statement does not replace your signature of the entire Privacy Notice which is displayed in our waiting room.

*HIPAA is the Health Insurance Portability and Accountability Act of 1996. It is a Federally mandated law that entitles the patient to protection of their Protected Health Information (PHI) and defines its acceptable uses for disclosure to others.

CANYON MEDICAL CENTER, Inc. may use your demographic or medical PHI for the following reasons:

- 1.) Treatment of any kind, including disclosing information to outside business associates such as laboratories or other healthcare facilities and providers.
- 2.) Payment of any service provided by CMC, any provider associated with our facility or any entity practicing as a business associate to CMC.
- 3.) General Healthcare Operations such as employee training or quality assurance.
- 4.) Any other reason required by law, public health reporting, or Worker's Compensation Compliance.

The reasons listed above are inclusive examples of the right to disclose but are not a complete listing of CMC or its provider's rights to disclose.

*HIPAA provides the patient with right to request a restriction of the disclosure or usage of their PHI for any reason. All requests for restrictions must be made in writing to CMC's Privacy Officer/Contact Person. However, a request for restriction must not be impeding to the care of the patient or the ability of CMC to obtain payment;

*If patients believe there has been a violation of their privacy rights implemented by HIPAA, they have the right to file a complaint to CMC, the Department of Health and Human Services, or both.

CANYON MEDICAL CENTER
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH
INFORMATION
ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the Practice's Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

Patient Name: _____

Patient Signature: _____ Date: _____