Optum

HIPAA Summary of Notice of Privacy Practices and Acknowledgment Form

By signing below, I acknowledge that Optum and/or a facility operated by, managed by or affiliated with Optum or any of its affiliates or subsidiaries has/have provided me with a complete copy of its/their Notice of Privacy Practices. This is a summary of the information in the complete Notice of Privacy Practices

My Rights. I have the right to:

- Get a copy of my paper or electronic medical record
- Request corrections to my paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
  Get a list of those with whom we've share your information
- Get a copy of the complete Notice of Privacy Practices
- File a complaint if I believe my privacy rights have been violated

My Choices. I have some choice in the way the facility uses and shares my information as it:

- Tells family and friends about my condition
- Assists in disaster relief efforts
- Markets its services and sells my information

We may use and share your information as we:

- Treat vou
- Run our organization
- Bill for services
- Help with public health and safety issues
- Do research
- Comply with applicable laws
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other governmental requests
- Respond to lawsuits and legal actions

I have had the opportunity to review the complete Notice of Privacy Practices prior to signing this acknowledgment. I am aware that the facility reserves the right to change the terms of their Notice of Privacy Practices and to make new provisions effective for all protected health information that they maintain. In the event of amendments), the facility will make available a revised Notice of privacy Practices on its website and at its treatment locations.

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Name of patient (please print) Date

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Signature of patient or personal representative

If Personal Representative signs, please state relationship to patient and explain authority to sign.

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