NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

FOR FURTHER INFORMATION
For Further Information you may contact the HIPAA Privacy Officer at 229-226-4241.

THIS NOTICE IS EFFECTIVE: February 3, 2014

HIPAA SECURITY OFFICER
The HIPAA Security Officer may also be reached at 229-226-4241 or by writing to:

HIPAA Security Officer
PO Box 148
Thomasville, GA 31799

SOUTHWEST PUBLIC HEALTH DISTRICT
www.southwestgeorgiapublichealth.org
HIPAA Acknowledgement

Patient Name: _____ **Date of Birth:** _____

Patient VHN #: _____

HIPAA: Notice of Privacy Practices Acknowledgement

Patient Initials

_____I was given an opportunity to read the Notice of Privacy Practices for the Thomas County Board of Health, and to take my copy with me, if I so desire.

_____ I wish to name one or more family members or others with whom the Health Department is authorized to share my protected health information to assist with my care or payment for care I receive. (List names in the space below.)

_____After reading the Notice of Privacy Practices, I wish to request restrictions on certain protected health information that the Thomas County Board of Health would normally share. I realize my request may be denied and that if it is denied, I will be notified in writing. (List requested restrictions below)

Family Members/Others:

_____

_____

Restrictions Requested:

_____

_____

Patient Signature: _____ **Date:** ____/____/____

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I offered the patient a copy of the Thomas County Board of Health's Notice of Privacy Practices on the date listed below. The patient refused to sign the acknowledgement.

Signature: _____ Date: ____/____/____