ROBERT E. MITCHELL, M.D.

695 HILL COUNTRY DR., STE B., KERRVILLE, TX 78028
830-257-2880

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

PATIENT NAME _____ DATE OF BIRTH _____

THE ***NOTICE*** PROVIDES IN DETAIL THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION THAT MAY BE MADE BY THIS PRACTICE, MY INDIVIDUAL RIGHTS AND THE PRACTICE'S LEGAL DUTIES WITH RESPECT TO MY PROTECTED HEALTH INFORMATION. THE ***NOTICE*** INCLUDES:

- A STATEMENT THAT THIS PRACTICE IS REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF PROTECTED HEALTH INFORMATION
- A STATEMENT THAT THIS PRACTICE IS REQUIRED TO ABIDE BY THE TERMS OF THE ***NOTICE*** CURRENTLY IN EFFECT.
- TYPES OF USES AND DISCLOSURES THAT THIS PRACTICE IS PERMITTED TO MAKE FOR EACH OF THE FOLLOWING PURPOSES: TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.
- A DESCRIPTION OF EACH OF THE OTHER PURPOSES FOR WHICH THIS PRACTICE IS PERMITTED OR REQUIRED TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION WITHOUT MY WRITTEN CONSENT OR AUTHORIZATION.
- A DESCRIPTION OF OTHER USES AND DISCLOSURES THAT WILL BE MADE ONLY WITH MY WRITTEN AUTHORIZATION AND THAT I MAY REVOKE SUCH AUTHORIZATION.
- THIS PRACTICE RESERVES THE RIGHT TO CHANGE THE TERMS OF ITS ***NOTICE OF PRIVACY PRACTICES*** AND TO MAKE NEW PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT IT MAINTAINS. I UNDERSTAND THAT I CAN OBTAIN THIS PRACTICE'S CURRENT ***NOTICE OF PRIVACY PRACTICES*** ON REQUEST.

NAMES OF INDIVIDUALS THAT I GIVE PERMISSION TO, TO HAVE ACCESS TO MY MEDICAL RECORDS ARE AS FOLLOWS---

INDIVIDUAL'S NAME	RELATIONSHIP TO PATIENT

SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT (IF SIGNED BY A PERSONAL REPRESENTATIVE OF PATIENT) : _____