

# MemoryCare

## NOTICE OF PRIVACY PRACTICES Acknowledgement of Receipt

- I have reviewed MemoryCare's Notice of Privacy Practices with a staff member and been given an opportunity to ask questions. I understand that MemoryCare may use or disclose my personal health information for the purposes of treatment, payment, and healthcare operations, including evaluating the quality of services provided and reporting to funding agencies. I understand that, if I notify the practice in writing, I have the right to restrict how my information is used and disclosed for treatment, payment, and healthcare operations. I, also, understand that MemoryCare will consider requests for restrictions on a case-by-case basis, but does not have to agree to such requests.

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- I hereby authorize MemoryCare, a charitable nonprofit organization, to use my protected health information for development activities. I understand this authorization does not affect my consent to use my protected health information for treatment, billing, or other healthcare operations and that I may revoke this consent at any time by notifying MemoryCare in writing.

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- I understand that MemoryCare is willing to communicate with me or my family via email, but cannot ensure its security. Please initial below if you approve of email communication with you or your family.

I approve using email to communicate.

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\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient or Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Representative to Patient

### FOR MemoryCare USE ONLY

If acknowledgement of receipt of Notice of Privacy Practices is not obtained from patient or representative, please explain efforts to obtain acknowledgement and the reasons you could not obtain it: \_\_\_\_\_

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