



Rheumatic Disease Associates, Ltd.

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WELCOME TO OUR PRACTICE

Your appointment is on _____ at _____ in the _____ office.

Please arrive 30 minutes prior to your scheduled time. For your first office visit you will need to bring the following:

- A list of your medications and Photo Identification
- Copies of any laboratory, x-ray reports, original films or hospital reports done in the last year.
- All insurance cards. If you cannot bring the original cards, please bring a copy of the front and back of all of your medical cards, including your prescription card. If you can not provide the cards or copies of the cards, your appointment will have to be rescheduled.

MEDICAL RECORDS: Patients are responsible to bring all records for their initial consultation, i.e. Relevant medical records including lab results and radiology reports.

IF WE DO NOT HAVE YOUR REPORTS YOUR APPOINTMENT MAY HAVE TO BE RESCHEDULED.

If your insurance requires a copay and/or a referral, they are expected at the time of your visit. Federal regulation mandates that all copayments must be paid in full and no exceptions can be made for any reason.

If we participate in your insurance plan, we will submit claims for you. If we do not participate in your insurance plan, payment is expected at the time of service. Any services deemed non-covered or deductibles are your responsibility.

We do not accept patients with an open auto or workers' compensation claim. If you have scheduled your appointment because of your case, kindly call the office to cancel your appointments. We do not accept Medicaid or Medical Assistance Plans as primary insurance.

For your convenience we accept cash, checks, most major credit cards, and debit cards. In addition, we offer Care Credit. Information on the Care Credit Plan is included on our website: www.arthritispa.com.

If you are unable to keep this initial appointment, kindly give 48 hours cancellation notice, otherwise you will be charged \$100.00 for the 45 minute reserved time.

During your appointment your doctor will take your history and perform a physical examination, concentrating on your muscles, bones, and joints. He or she will discuss their thoughts about your problem and its treatment. Should you need x-rays or laboratory studies, our nurses or front desk receptionists will be happy to direct you to the appropriate facility. All test results will be given to you at the time of your return appointment. Should your tests need attention prior to your return, we will contact you.

The physicians at Rheumatic Disease Associates do not discuss billing issues with their patients. All billing inquiries need to be directed to the Billing Department. For infusion inquiries dial extension 124 or 126. For all other inquiries dial extension 125 or 308.

If you have any questions please feel free to call us at 215-657-6776. We look forward to your visit and sincerely hope that we can help you!

Specializing in Rheumatoid Arthritis, Osteoarthritis, Osteoporosis, Lupus, Lyme Disease

Main Office:
2360 Maryland Road
Willow Grove, PA 19090
Phone: 215-657-6776
Fax: 267-913-5961

Other Offices:
Huntingdon Valley
2301 Huntingdon Pike
First Floor
Huntingdon Valley, PA 19006
Phone: 215-657-6776
Fax: 215-947-4204

The Pavilion
599 West State Street
Suite 310
Doylestown, PA 18901
Phone: 267-893-6780
Fax: 267-893-6784

Rheumatic Disease Associates LTD

2360 Maryland Road
Willow Grove, PA 19090-1709
(215) 657-6776

PATIENT INFORMATION									
NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	LANGUAGE	SEX	
LOCAL ADDRESS		CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS		ETHNICITY	
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE ZIP		RACE	
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE		
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)					
ADDRESS				ADDRESS					
CITY, STATE ZIP				CITY, STATE ZIP					
WORK PHONE				WORK PHONE					

RESPONSIBLE PARTY INFORMATION (if Different than above)									
NAME (Last, First Middle)				SSN#	BIRTHDATE	LANGUAGE	SEX		
LOCAL ADDRESS		CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)					
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP					
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE				
RELATIONSHIP TO PATIENT									

PRIMARY INSURANCE									
NAME OF INSURANCE COMPANY				POLICY#					
NAME OF INSURED				GROUP#					
ADDRESS OF INSURANCE COMPANY				COPAY AMT		\$			
CITY, STATE ZIP		PHONE		DEDUCTIBLE		\$			
RELATIONSHIP TO PATIENT				EFFECTIVE DATE			EXPIRATION DATE		

SECONDARY INSURANCE (if Applicable)									
NAME OF INSURANCE COMPANY				POLICY#					
NAME OF INSURED				GROUP#					
ADDRESS OF INSURANCE COMPANY				COPAY AMT		\$			
CITY, STATE ZIP		PHONE		DEDUCTIBLE		\$			
RELATIONSHIP TO PATIENT				EFFECTIVE DATE			EXPIRATION DATE		

I request that payment of any and all authorized insurance benefits be made either to me or on my behalf to Rheumatic Disease Associates, Ltd. for professional services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance. Should my account be forwarded to collections, I understand and agree as the patient or my dependent that all legal and collection fees are my responsibility.

(PLEASE TURN PAGE FOR INSURANCE AUTHORIZATIONS)

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

AUTHORIZATIONS

ALL PATIENTS

I authorize any holder of medical or other information about me to release this information to my insurance company, its intermediaries or carriers, to my attorney or another physician's office.

I hereby authorize direct payment of medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, Private Insurance, and any other health plan to Rheumatic Disease Associates, LTD.

I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.

I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by insurance.

Signature of patient or responsible party

Date

MEDICARE PATIENTS

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Rheumatic Disease Associates, LTD for any services furnished me by Rheumatic Disease Associates, LTD. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Medicare Beneficiary Signature

Date

Medicare Number



Patient History Form

Rheumatic Disease Associates, Ltd.

Patient Name: _____ DOB: _____

Primary Care Physician's name, address, telephone number: _____

Reason for today's visit: _____

Current medical conditions: _____

Current prescription and non-prescription medications: _____

Past Medications for arthritis or arthritis-related problems: _____

Past medical history (including surgeries): _____

Family medical history (please include which family member such as parent, sibling):

Medication Allergies: _____

Women only: Age at menopause _____ Do you drink milk? Y / N

Do you take vitamins and/or calcium supplements? Y / N

Preferred Pharmacy: _____ Phone number: _____

Address/location: _____

If appropriate, would you be interested in participating in Clinical Trials for new treatment of your disease at no cost to you? Y / N

Name: _____

Date: _____

Select the response which best describes the patient's usual abilities over the past week

	Without Any Difficulty	With Some Difficulty	With Much Difficulty	Unable To Do
Is the patient able to get on and off the toilet?	0	1	2	3
Is the patient able to open car doors?	0	1	2	3
Is the patient able to stand up from a chair?	0	1	2	3
Is the patient able to walk outdoors on flat ground?	0	1	2	3
Is the patient able to wait in a line for 15 minutes?	0	1	2	3
Is the patient able to reach and get down a 5 pound object from above his or her head?	0	1	2	3
Is the patient able to go up 2 or more flights of stairs?	0	1	2	3
Is the patient able to do outside work?	0	1	2	3
Is the patient able to lift heavy objects?	0	1	2	3
Is the patient able to move heavy objects?	0	1	2	3

Please circle one rating for your pain



0

No Pain

1



2

Mild Pain

3



4

Discomforting

5



6

Distressing

7



8

Intense

9



10

Excruciating

RHEUMATIC DISEASE ASSOCIATES, LTD.

RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I, _____, have received the Rheumatic Disease Associates
(print patient's name)

Notice of Privacy Practices. This form will become a part of my medical record.

Patient's signature: _____ Date received: _____

Patient's Date of Birth: _____

If received by another responsible party, please print name and relationship to patient:

Responsible Party's Signature: _____

Permission for release of patient's private health information

Rheumatic Disease Associates is permitted to release my Private Health Information to:

(Print name) (relationship)

By means of: (check all that apply)

_____ phone _____ message on answering machine

_____ copies of records _____ in person

And/or to:

(Print name) (relationship)

By means of: _____ phone _____ message on answering machine

_____ copies of records _____ in person

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT YOU AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This notice describes Rheumatic Disease Associates' privacy practices. All entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

Our Pledge Regarding Health Information

We understand that information about you, your health, and your health care is personal. We are committed to protecting the security of that information, your protected health information (PHI), and to preventing its disclosure without your authorization, when required.

We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this organization. This notice tells you about the ways in which we may use and disclose your PHI. We also describe your rights to the PHI that we keep about you and explain our obligations regarding the use and disclosure of your PHI.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Provide you with this notice of our legal duties and privacy practices with respect to your PHI
- Follow the terms of the notice that is currently in effect
- Notify you if there is a security breach of protected health information (PHI) except when the PHI is encrypted is disposed of securely

How We May Use and Disclose Your PHI

The following categories describe different ways that we use and disclose health information. Within each category, we have provided a list of examples.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to physicians, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices; at the hospital if you are hospitalized under our supervision; or at another physician's office, lab, pharmacy, or other health care provider where we may have referred you for x-rays, laboratory tests, prescriptions, or other treatment purposes. For example, a physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the physician may need to tell the hospital dietician about your diabetes so we can arrange for appropriate meals. We may also disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

For Payment: We may use and disclose information about treatment and services we provided to you for billing purposes. The information may include monies that we have received from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so the plan will either pay us or reimburse you for the visit. We may also tell your health plan about a treatment before you receive it so that we can obtain prior approval, if required, or determine if your plan will cover the treatment. If we provide a service for which you pay in full out-of-pocket and you request that we not send PHI to your insurance company, we are obligated to comply with your request except when the information is needed to comply with the law.

For Health Care Operations: We may use and disclose protected health information about you for the operation of our organization. These uses and disclosures are necessary to run Rheumatic Disease Associates and to make sure that all our patients receive quality care. For example, we may use health information in a general review of our treatments and services or, more specifically, to evaluate the performance of our staff in caring for you. We may also combine the health information of many patients to decide what improvement we could make, what additional services we should offer, what services are not needed, or whether certain new treatments are effective. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning the individual identity of specific patients.

Marketing: We will seek and obtain your prior written authorization for all written communications to you regarding treatment and healthcare operations where we have received financial remuneration from (or on behalf of) a third party in exchange for sending the communication; and the communication is intended to encourage purchase or use of a product or service offered by the third party. This requirement may apply to appointment reminders, treatment reminders, alternative treatments, and healthcare products and services. The requirement does not apply to face-to-face communications; promotional gifts of "nominal" value; prescription refill reminders or other communications about a drug or biologic that is being prescribed for you if the financial remuneration received is reasonably related to our cost for making the communication; communications about general health; and communications about government or government-sponsored programs.

Health-Related Services and Treatment Alternatives: We may use and disclose protected health information (PHI) to tell you about health-related services or recommend possible treatment options or alternatives that may be of interest to you. Please let us know if you do not wish us to send you this information or if you wish us to send this information to a different address.

Appointment Reminders: We may use and disclose protected health information to contact you as a reminder that you have an appointment or that you missed an appointment and should contact us to reschedule. Please let us know if you do not wish to have us contact you for this purpose or if you wish us to contact you at a different address.

Fundraising Activities: From time to time we may use your protected health information (PHI) to contact you in an effort to raise money for our not-for-profit operations. We may disclose health information to a business associate that may then contact you to raise money for our practice. We only will release contact information, such as your name, address, and phone number, and the dates you received treatment or services from us. In these instances, as well as in all future fundraising activities, we will give you the option to opt out of the fundraising communication.

Sale: From time to time we may sell your protected health information (PHI) for financial or other remuneration. For example, a researcher may pay us a fee that exceeds the reasonable cost to prepare and transmit the PHI. We will obtain your prior authorization for the use and disclosure of protected health information (PHI) for sales purposes.

Research: Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another medication for the same condition. The physicians of Rheumatic Disease Associates must approve all research projects. The physicians and our research department evaluate all potential projects and select those that will be of direct or indirect benefit to our patients and/or community. Their review process also evaluates a proposed research project's use of health information, trying to balance the needs of the research community with patients' need for privacy. We will obtain your written authorization to use your PHI for research purposes *except* when our research staff has determined that:

- The use or disclosure involves no more than a minimal risk to your privacy based on the following:
 - An adequate plan to protect the identifying information from improper use and disclosure;
 - An adequate plan to destroy the identifying information at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and
 - Adequate written assurances that the PHI will not be reused or disclosed to any other person or entity (except as required by law for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted);
- The research could not practically be conducted without the waiver; and
- The research could not practically be conducted without access to and use of the PHI.

Before we use or disclose health information for research, the project will have been approved through our research approval process. However, we may disclose health information about you to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, as long as the health information they review does not leave our facility.

Organ and Tissue Donation: If you are an organ donor, we may release health information to an organ donation bank or to organizations that handle organ procurement or organ, eye, or tissue transplantation, as necessary to facilitate organ or tissue donation and transplantation.

As Required by Law: We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans: If you are a member of the armed forces or separated or discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans' Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health activities. These activities generally include the following:

- The prevention or control of disease, injury, or disability
- The reporting of births and deaths
- The reporting of child abuse or neglect
- The reporting of reactions to medications or problems with products
- The notification of people about recalls of products they may be using
- The notification of a person or organization required to receive information on Food and Drug Administration-regulated products
- The notification of a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- The notification of the appropriate government authority, if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure if you agree or when required or authorized by law)

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your health information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do that by a law enforcement official:

- In reporting certain injuries, as required by law: gunshot wounds, burns, dog bites, and injuries to perpetrators of crime
- In response to a court order, subpoena, warrant, summons, or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person (name and address, date of birth or place of birth, social security number, blood type or Rh factor, type of injury, date and time of treatment and/or death, if applicable, and a description of distinguishing physical characteristics)
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at our facility
- In emergency circumstances to report a crime; the location of a crime or victims; or the identity, description, or location of a person who committed a crime

Coroners, Health Examiners, and Funeral Directors: We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose health information about you to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your Rights Regarding Health Information About You

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information such as medical and billing records that may be used to make decisions about your care.

In order to request inspection and copying of health information that may be used to make decisions about you, submit a written request to our Medical Records Department which can be reached at 215-857-6776 extension 134. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request review of the denial. This review will be conducted by another licensed health care professional chosen by our organization, in most cases one of our physicians. The person conducting the review will not be the person who denied your request. This practice will comply with the outcome of the review.

Right to Request Information in a Form of Your Choosing: You have the right to request the provision of protected health information (PHI) in a form of your choice such as paper or electronic. We will grant or deny the request within 30 days, and we may at times request a 30-day extension period. If any of the protected health information (PHI) is stored off-site, we will respond to your request within 60 days. We may charge you a reasonable, cost-based fee for preparing the information that you request.

Right to Request that We Send Information to Other Designated Parties: You have the right to request that we send copies of your protected health information (PHI) to other designated parties, provided that you submit a written signed request, designating the name, identity, and correct address of the designated recipient.

Right to Amend: If you believe that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing on the Request for Correction/Amendment of Protected Health Information form and submitted to "Medical Records Department, Rheumatic Disease Associates, 2360 Maryland Road, Willow Grove, PA 19090". On the form you must include information supporting and the reasons for your request.

We may deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information kept by or for our practice
- Is not part of the information that you would be permitted to inspect and copy
- Is accurate and complete

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list of the disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing to "Medical Records Department, Rheumatic Disease Associates, 2360 Maryland Road, Willow Grove, PA 19090". Your request must state a time period that may not be longer than 6 years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in writing within 30 days of your request. If we are unable to provide you with this information within 30 days, we will notify you of that fact and inform you of the date by which we can supply the list. This date will not be more than 60 days from the date you made the request.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we withhold your information from a specified nurse or that we not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively affect the care we provide you.

If we do agree, we will comply with your request, unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to this office's "Medical Records Department, Rheumatic Disease Associates, 2360 Maryland Road, Willow Grove, PA 19090" to Request Restrictions on the Use and Disclosure of PHI form. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, you must make your request in writing to this office's "Medical Records Department, Rheumatic Disease Associates, 2360 Maryland Road, Willow Grove, PA 19090" on the To Request Confidential Handling of Specified Health Information form. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

Right to Request Withholding of Disclosures Health Plans: If you pay out-of-pocket in full for a service that we provide, you may request that we withhold from the payer disclosure of information on that service. We are obligated to comply with that request unless non-disclosure is required by law.

Right to Request Withholding of Use and Disclosure of Psychotherapy Notes: You may request that we withhold use and disclosure of psychotherapy notes related to care we provide for you.

Right to Be Notified Should there Be a Breach: You have the right to receive notice from us regarding a breach in disclosure of protected health information (PHI).

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from this office's Medical Records Department at 215-657-6776 extension 134.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at each of our sites and on our website. The notice will contain on the first page, at the top, the effective date. You may request a copy of our most current notice at any time.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services in Washington, DC. To file a complaint with us, complete our Patient Comment and Privacy Complaint Form. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information (PHI) about you for the reasons covered by your written authorization. We cannot revoke any disclosures that we have already made with your permission. We are required to retain our records of the care that we provided to you.

Acknowledgment of Receipt of This Notice

We will request that you sign a separate form acknowledging that you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign his or her name and date. This acknowledgment will be filed with your records.