Independence Park Medical Services, Inc

HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (*name of patient*) ________________________________, acknowledge and agree that I have received a copy of **Independence Park Medical Services, Inc.'s** notice of **Privacy Practices**.

__________________________________ __________________

Signature **Date**

__________________________________ ______________________

Print Name of Responsible Party (if applicable) **Relationship to Patient**

FOR CLINIC USE ONLY:

Independence Park Medical Services, Inc. made the following good faith efforts to obtain the above referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices:

> **[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]**

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We participate with healtheConnect the Alaska health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about healtheConnect medical record sharing policies at www.healtheconnectak.org.