J C Center for Psychiatric Services

43200 Dequindre Rd., Suite 104
Sterling Heights, MI 48314
Phone: (586) 799-4350
Fax: (586) 799-4279

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY INFORMATION PRACTICES

My signature on this form indicates that I have received a Notice of Privacy Information Practices.

In the event that I have questions, I have been given the name of the Privacy Officer, whose information is listed below, who will be able to answer my questions.

Privacy Officer
Office Manager
43200 Dequindre Rd., Suite 104
Sterling Heights, MI 48314
Phone: (586) 799-4350

I request the following person(s) to receive information regarding my protected health information

Name: Relation: _____ Birth date: _____

Name: Relation: _____ Birth date: _____

Name: Relation: _____ Birth date: _____

You as a parent or patient have the right to:

1. Request an amendment to your/your dependent's medical records if you feel they are incorrect or incomplete. The physician may deny my request and notify me of the reason for his/her decision.
2. Request an accounting of disclosures. This is a list of disclosures for other than treatment, payment or health care operations.
3. Request a restriction of limitation of the medical information used or disclosed about me/my dependant for treatment, payment or health care operations. All requests must be in writing. However, the physician has the right to deny the restriction. If he/she does agree to the restriction, the office will comply with your request unless the information is needed to provide you with emergency care.

_____ _____

Signature of Patient or Legal Representative Date

OFFICE USE ONLY:

_____Patient/legal guardian refused to sign consent, despite a good faith effort to receive acknowledgement.

EMPLOYEE SIGNATURE: _____ Date: _____