ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, (Patient), acknowledge that Lane Regional Medical Center (LRMC) has provided me with a copy of its Notice of Privacy Practices.

_____ _____

Signature of Patient or Authorized Representative Date

(OPTIONAL: To be completed if Patient desires to request restrictions on the use or disclosure of health information.)

I understand that LRMC may use and disclose my health information in any manner set forth in the Notice of Privacy Practices.

I further understand that I may request restrictions on the uses and disclosures of my health information in the situations described in the Notice of Privacy Practices.

I understand that LRMC is not obligated to agree with the restrictions. I also understand that if LRMC does agree, such restrictions may be terminated by me or LRMC in appropriate circumstances.

I further understand that I am not required to request restrictions at this time and that I may request restrictions at a later date by submitting a written request to LRMC.

Accordingly, I wish to request the following restrictions on the use and disclosure of my health information.

_____

_____

_____

_____ _____

Signature of Patient Date

_____ _____

Signature of Legally Authorized Representative (if applicable) Date

_____ _____

Phone

_____

_____

Address