

Acknowledgement of Receipt of Notice

I understand and hereby acknowledge that Hutcheson Medical Center is part of an organized healthcare arrangement that includes the following entities: **Hutcheson Medical Center, Inc., Hutcheson Home Health, Hutcheson Hospice, SubAcute Care Unit at Hutcheson, Hutcheson Employee Health Plan Pharmacy, Parkside at Hutcheson, Hutcheson Rehabilitation Facilities, Battlefield Imaging, Inc., The Diabetes and Thyroid Treatment Center at Hutcheson on the Parkway, Battlefield Pulmonary Associates, Inc. and any and all other entities that are either currently or that hereinafter become similarly affiliated in said organized healthcare arrangement.** These providers may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's Notice of Privacy Practices that describes my patient rights and how my health information is used and shared. I understand that Hutcheson Medical Center has the right to change this notice at any time. Updated notices may be obtained by contacting the hospital Registration Office, the Privacy Officer or by visiting the web site at: www.hutcheson.org

My signature below constitutes my acknowledgement that I have been provided with a Notice of Privacy Practices.

_____ Date _____
Signature of Patient
Or Personal Representative as
Designated in patient's Durable Healthcare Power of Attorney

For HMC use only: Special Circumstances: <input type="checkbox"/> Patient Unable to Sign Due to Condition <input type="checkbox"/> Other _____ Personnel Obtaining Release: _____ Date _____
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