



Acknowledgment of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my care among a number of staff and health care providers who may be involved in attendance and treatments directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessments and improvement activities.

I have been informed of camp's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that Camp Courageous of Iowa has the right to change the Notice of Privacy Practices and that I may contact the camp office at the address above to obtain a current copy of the Notice of Privacy Practices .

I understand that I may request in writing that Camp Courageous restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Camper's Name: _____

Camper's Signature: _____
(if own legal guardian)

Date: _____

Guardian's Signature: _____

Date: _____

Relation to Camper: _____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy due to the following reason:

The patient refused to sign

Emergency Situation

Communication barriers

Other: _____