

PRIVACY POLICY
LONGWOOD UNIVERSITY HEALTH SERVICES

Acknowledgement of receipt of the Notice of Privacy Practices

I understand and have been provided with the Notice of Privacy Practices that provides a detailed description of medical information uses and disclosures.

I understand that I have the right to review the notice prior to signing this acknowledgment form.

I understand that the organization reserves the right to change their notice and practices. The change will be posted in the Health Center and available to me on the Longwood web site.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Potomac Healthcare Solutions is not required to agree to the restrictions requested.

I understand that I may revoke this acknowledgment in writing, except to the extent that the organization has already taken action in the reliance thereon.

Signature of Patient or Legal Representative

Date

If representative, define the relationship to the patient. _____