Medical Affiliated Research Center
303 Williams Ave. Suite 511
Huntsville, AL 35801
(256) 533 - 6603

North Alabama Research Center
721 W. Market St. Suite B
Athens, AL 35611
(256) 771 - 9919

Cullman Research Center
909 Graham St. SW Suite D
Cullman, AL 35055
(256) 735 - 4262

HIPAA MEDICAL INFORMATION

****NOTICE OF PRIVACY PRACTICES****

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights, and control of how your health information is used. HIPAA provides the penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy or your health information and how we may use and disclose your health information.

We understand that information about you and your health is personal and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we can use or disclose your protected health information for research purposes. The authorization can be part of the consent or a separate authorization can be used.

We may need to review or receive certain medical records of yours for research study participation as needed but said records will not be reviewed or used without your authorization.

You have the following rights with the respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- You will not be allowed to see or copy the information collected in this research trial, but you have the right to see and copy the information upon completion of the research trial.
- You will have the right to amend your protected health information.
- You will have the right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- You will have the right to receive an accounting of disclosures of protected health information.
- You will have a right to obtain a paper copy of this notice.

****NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT****

I have received, read, and understood the New Horizon Research Group, Inc. *Notice of Privacy Practices*. I understand that this organization has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also 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.

Patient Name (PLEASE PRINT): _____

Patient Signature: _____ **Date:** _____/_____/_____

Witness Signature: _____ **Date:** _____/_____/_____