



# Chadron Community Hospital & Health Services Privacy Notice

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Print Name of Patient

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Medical Record #

I understand that as part of my health care, this organization originates and maintains health records describing my health history, symptoms examinations and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information on my bill
- A means by which a third-party payer can verify that services were actually provided
- And a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided.

I understand that confidentiality will be protected except as required by law.

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Signature of Patient or Legal Representative

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Date

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Witness