MOUNTAIN LAUREL
MEDICAL CENTER

1027 Memorial Drive
Oakland, MD 21550

104 Parkview Drive
Grantsville, MD 21536

Phone (301) 533-3300
Fax (301) 533-3299

Mountain Laurel Medical Center is dedicated to providing healthcare services to the residents of the local communities. Because physical and emotional problems often go together, we believe the best care is given when healthcare providers work together. MLMC patients may be referred to providers from other healthcare specialties either within the health center treatment team or to an external provider if needed.

Patients are seen by appointment and walk-in. Patients must call in advance if they cannot keep their appointment.

Information about a patient will not be given to anyone outside of MLMC, including family and friends, unless the patient (parent or legal guardian if a minor) gives written permission. However, we may release patient information to others without the patient's permission if 1) the patient poses a threat to him/herself or others 2) the patient is unable to protect him/herself from risk of harm; 3) the patient is in the legal custody of a government agency or facility; 4) there is evidence of child abuse; or 5) the patient's clinical records are requested under court order.
As part of the treatment team, patient's information is sent to any referring provider or consultant for proper coordination of care.

Acknowledgement of Receipt of Notice of Privacy Practices
I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician credentialing. I am aware that your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information is available at my request. I understand Mountain Laurel Medical Center has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the above to obtain a current copy of the *Notice of Privacy Practices,* as required by law.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I have read or requested a copy of the *Notice of Privacy Practices* for Mountain Laurel Medical Center and understand the above information.

I hereby ask and agree to evaluation and treatment for myself and/ or my children, including any studies or procedures the MLMC professional staff decides are necessary.

Signature

Signature of Patient _____ **Date** _____

Signature of Patient Representative _____ **Date** _____
(Required if patient is a minor or an adult unable to sign this form)