NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

This Notice of Privacy Practices describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain .about you and a brief description of how you may exercise these rights. This Notice also explains the obligations we have to protect your health information.

"Protected Health Information" (PHI) means health information (including identifying information about you) we have collected from you or received from your health care providers, health plans, your employer or a health care clearinghouse. It may include information about your past, present or future physical or.mental health condition, the provision of your health care, and payment for your health care services.

We are required by law to maintain the privacy of your health information and to provide you with this notice of our legal duties and privacy practices with respect to your health information. We are also required to comply with the terms of our current Notice of Privacy Practices

You have the right to obtain a paper copy of this Notice of Privacy Practices at any time. To obtain a paper copy, contact the ILI Privacy Officer at (845) 565-1162, ext. 222, or request a copy from the ILI staff person who works with you. You can also view a copy on Independent Living, Inc.'s website at www.myindependentliving.org. It is located in the "About"> "Policies" section.

We reserve the right to change the terms of our Notice of Privacy Practices. We also reserve the right to make the revised or changed Notice of Privacy Practices effective for all health information we already have about you as well as any health information we receive in the future. We shall post a copy of the current Notice of Privacy Practices at our main office and at each site where we provide care.

CONSUMER UNDERSTANDING AND SIGNATURE

By signing this form, I have read the above statements and understand ILI's HIPAA Notice of Privacy practices and consent to Ill's use and disclosure of my protected health information/or the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

I make the following request/or confidential communication or restriction on use or disclosure of my protected health information.

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_____
Signature of Consumer or Personal Representative

_____
Print Name of Consumer or Personal Representative

_____
Date

_____
Description of Personal representative's Authority