YOUR PRIVACY RIGHTS

The following is a summary of your rights with respect to your protected health information: (Please be aware that Schneider Regional Medical Center can deny your requests in certain circumstances.)

You may request a restriction on uses and disclosures of your health information.
You may request that our communications to you be confidential.
You may request to inspect and copy your protected health information (we may charge a fee for copying your record.)
You may request an accounting of disclosures of your health information.
You may request an amendment of your protected health information.
You have the right to receive a copy of the complete Notice of Privacy Practices.

You should also know that is you have greater protection under a specific U.S. Virgin Island statute or regulation, those protections will continue to apply to you.

COMPLAINTS or ADDITIONAL INFORMATION

You may file a complaint to us to the Secretary of Health and Human Services If you believe that we have violated your privacy rights. You may also request additional information about the Notice of Privacy Practices.

Write to:
Roy Lester Schneider Hospital
Attention: Patricia Lake-Blyden
Privacy Official
9048 Sugar Estate
St. Thomas, U.S.V.I. 00802

Other Complaint Filing Information:

You may file a complaint with the
USVI Department of Health
Write to:
Commissioner of Health
9048 Sugar Estate, 5th Floor
St. Thomas, U.S.V.I. 00802

You may file a complaint with the
Peer Review Organization
Write to:
Peer Review Organization
#1AD Estate Diamond Ruby
PO Box 5989, Sunny Isle
St. Croix, VI 00823

EFFECTIVE DATE

This notice is effective February 22, 2007.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Medical Record Number
_____

I, _____,
(Print your name)
Acknowledge that I have been informed of the *Notice of Privacy Practices* by Schneider Regional Medical Center (SRMC) and I am aware that I have the right to a printed copy of the Notice upon my request.

Patient or Patient Representative	**Received by SRMC:**
Signature:	**Signature:**
Social Security #:	**Department:**
Date:	**Date:**
If signing as a Personal Representative Relationship to patient:	

For SRMC use only
Complete the section below is unable to obtain acknowledge of receipt from patient.

Despite a good faith effort to do so, SRMC has been unable to obtain written acknowledgement of receipt of Notice of Privacy Practices from the following patient:

_____ for the following reason:
(Patient Name)
_____

SRMC:
Signature:
Department:
Date: