

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (:HIPPA), I have certain rights of privacy regarding my protected health information. I understand that this information can and will be use to:

- * Conduct, plan and direct my treatment and follow-up among the multiple Healthcare providers who may be involved that treatment directly and indirectly.
- * Obtain payment from third-party payers.
- * Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. In understand that this organization has the right to change it Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private 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 you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ **Relationship to Patient:** Self

Date: _____ **Signature** _____

OFFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ **Initials:** _____ **Reason:** _____