# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the health insurance portability and 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 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. I understand that this organization has the right to change its notice of privacy practice from time to time and that I may contact this organization at any time at the practice address to obtain a current copy of the notice of private practices.

I understand that I may request in writing that you reprint 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 requested restrictions but if you do agree then you are bound to abide by such restrictions.

PATIENT'S NAME: ______________________________

RELATIONSHIP TO PATIENT: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________

## OFFICE 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: ______________________________