

**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, however, 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 payments 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 PRACTICES* from time to time and that I may contact the organization at any time at the address above to obtain a current copy of the *NOTICE OF PRIVACY 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 requested restrictions, but if you agree, then you are bound to abide by such restrictions.

**Patient Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

I attempted to the patient's signature in acknowledgement on this *NOTICE OF PRIVACY PRACTICES* but was unable to do so as documented above.

Date:

Initials:

Reason: