NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & 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 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 acknowledge that I have viewed the *HIPAA 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 *HIPAA Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *HIPAA 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 do agree than you are bound to abide by such restrictions.

Patient Name: _____

Patient or Authorized Agent Signature: _____

Relationship to Patient: _____

Date: _____

Office Use Only:

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

Date: _____ Initials: _____ Reason: _____