

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 the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among 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 medical certifications.

I have read and understand your *Notice of Privacy Practices* containing a more complete description of the permitted uses and disclosures of my health information. I understand that this organization has the right to change the *Notice of Privacy Practices* and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*. This authorization will be in effect for one year from the date of signing unless otherwise requested otherwise in writing.

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 other healthcare operations.

Patient name (print): _____

Relationship to patient (other than self): _____

Signature: _____ Date: _____

For Office Use Only

I attempted to obtain the patient's signature and acknowledgment on this *Notice of Privacy Practices*, but was unable to do so as indicated by signage below:

Office Personnel Name (print): _____

Signature: _____ Date: _____

Reason: _____