

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), 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 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 requested restrictions, but if you do agree then you are bound to abide by

such restrictions.

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

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

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

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

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices

Acknowledgement, but was unable to do so as documented below.

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| --- | --- | --- |
| Date: | Initials: | Reason: |