

Notice of Privacy Practices Acknowledgement



I understand that, under the Health Insurance Portability & Accountability Act of 1969 (“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 certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to changes its 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 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 request 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 patient’s signature in acknowledgment on this Notice of Privacy Practices but was unable to do so as documented below.

Initials _____

Date _____

Reason _____
