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# 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 provides 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.

The *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information, is posted in this office, and I have been offered a copy of this notice. I understand that this organization has the right to change 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 to disclose, to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my personal restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature of Patient: _____ Date: _____

Patient Name (Printed): _____

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OFFICE USE ONLY

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

Date: _____ Name: _____ Initials : _____
Reason: _____