Acknowledge of Receipt of Notice of Privacy Practices

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 this information can and will be used for the following:

*Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in the treatment directly or indirectly

*Obtain payment from third party payers and confirm coverage

*Conduct normal healthcare operations such as quality assessments and physician certifications

*Confirm appointments using email, text, voicemail, postcards, or letters

*Disclose health information to a family member, friend, or caregiver to the extent necessary to help you with your healthcare

I acknowledge that I have read and/or received the 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 Notice of Privacy Practices from time to time and I may contact this organization at any time 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 our treatment, payment, or healthcare information. I also understand that 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_____

Signature of Patient (or Guardian if under 18)_____

Date_____