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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 the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.

I acknowledge that I have read 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 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 requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:

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Relationship to Patient:

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Signature:

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### OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgment of this Notice of Privacy Practices , but was unable to do so as documented below:

Date:

Initials:

Reason: