NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

I understand that, under the Health Information 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 to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or 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 complex 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 below 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 healthcare 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:

THIS COPY IS TO REMAIN IN PATIENT FILES AT ALL TIMES

OFFICE USE ONLY

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

DATE: **INITIALS:** **REASON:**