



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgment****

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have a certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received 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 below to obtain a current copy of *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 than you are bound to abide by such restrictions.

PLEASE PRINT NAME

SIGNATURE

RELATIONSHIP TO PATIENT

DATE

For Office Use Only

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

Date	Initials	Reason