

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

**I understand that, under the Health Insurance Portability 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 the treatment directly and 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 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 Private Practices.

I understand that I may request in writing that your restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are no required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

---

Patient Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

---

OFFICE USE ONLY

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