Privacy Practices Acknowledgement

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 to:

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

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 myrequest restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name _____

Patient Signature_____Date _____

If patient is unable to sign, responsible party _____

Relationship to patient _____

Signature_____Date _____

Office Use Only

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

Date:_____Initials:_____Reason: _____