HIPAA Notice of Privacy Practices Acknowledgement

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I understand that, under the Health Insurance Portability & 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 or indirectly.
- Obtain payment from third party payers.
- Conduct normal health care operations such as quality assessments and professional certifications.

I have received, read, and understand your HIPAA Notice of Privacy Practices containing a more complete and detailed description of the uses and disclosures of my health information. I understand that this office has the has the right to change its HIPAA Notice of Privacy Practices from time to time as necessitated by changes in HIPAA. I have the right, at any time, to contact this office at the address above to obtain a current copy of their HIPAA 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 that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient name (print) ______________________________________

Relationship to patient______________________________________

Signature _____________________________ Date_____________

OFFICE USE ONLY

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

Date: _____________ Initials: ________ Reason: ____