

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (δHIPAAö), 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 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 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 my requested 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 Practices Acknowledgement form, but was unable to do so as documented below:

Date \_\_\_\_\_ Initials \_\_\_\_\_ Reason \_\_\_\_\_

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION**

PLEASE LIST ANY PERSON WITH WHOM WE MAY DISCUSS YOUR HEALTH INFORMATION

NAME	RELATIONSHIP	PHONE
_____	_____	_____
_____	_____	_____

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_