Notice of Privacy Practices Acknowledgement

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 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 my treatment, directly and indirectly;

Obtain payment for services and/or items provided;

Conduct normal health care operations such as quality assessments.

I have reviewed your Notice of Privacy Practices that provides a more complete description of the uses and disclosures of my health information. I understand you have the right to change its Notice of Privacy Practices from time to time. I also understand I may contact you at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation activities. I also understand you are not required to agree to my requested restrictions.

Patient's Name: _____

Relation to Patient: [ ] Self [ ] Other: _____

Signature of Patient/Authorized Individual: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so for the following reason(s):

_____ Date: _____