

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 that this information can and will be used for the:

- ◆ Treatment of me by multiple healthcare providers who may be involved
- ◆ Reimbursement by my insurance company for any treatment received
- ◆ Normal healthcare operations, i.e. audit reviews, 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 protected health information. I understand that you have the right to change your *Notice of Privacy Practices* at any time and that I may contact you for a current copy.

I understand that I may request, in writing, any restrictions on how my protected health information may be used or disclosed and that you are not required to agree to my requested restrictions, however, if you do agree, you are then bound to abide by the 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, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____