

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information (PHI). 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 THE TREATMENT DIRECTLY AND INDIRECTLY.**
- **OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.**
- **CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.**

I was offered a copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. 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 to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian: _____
(print)

Signature: _____

Date: _____

PRACTICE USE ONLY

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

Date: _____ Initials: _____ Reason: _____