# 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:**

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.**
- **Obtain payment from a third party.**
- **Conduct normal healthcare operations such as quality assessments and physician certification.**

**I acknowledge that I have your *"Notice of Privacy Practices"* contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *"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 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 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: _____ DATE: _____**

**RELATIONSHIP TO PATIENT: _____**

**Release of Information**

**( ) I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:**

**( ) Spouse _____**

**( ) Children _____**

**( ) Other _____**

**( ) Information is not to be released to anyone.**

**SIGNATURE: _____**

## OFFICE USE ONLY

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