ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

You may refuse to sign this 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 to:

1. Conduct, plan and direct my treatment and follow up among the multiple health care provides who may be involved in that treatment directly and indirectly
2. Obtain payment from third party payers
3. Conduct normal health care operation such as quality assessments and physicians certifications.

I have received, read, and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that 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 operation. I also understand that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

Patient Name (print):_____.

Relationship to patient: _____.

Signature: _____Date:_____.

Request for confidential communications

Name of Patient: _____Date of Birth: _____.

Please write down the detail you request regarding how we should communicate with you.

(only if you have a request)

_____.

_____.

********OFFICE USE ONLY********

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices but was unable to do so as documented below.

Date: _____Reason: _____Initials: _____.