Notice of Privacy Practices
Patient Acknowledgement

I understand that, under the Health Insurance Portability & Account Act of 1996 (HIPAA), 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 health care providers who may be involved in the treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations

I have read and understand that I may submit a written request how my PHI is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are abound to abide by them.

Patient Name: _____

Relationship to Patient: _____

_____

Signature Date

OFFICIAL USE ONLY

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

Date Initials Reason