**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT (HIPAA)**

|  |  |
| --- | --- |
| **First Name:** | **Last Name:** |

I understand that, under the Health Insurance Portability and Accountability Act of 1998 (HIPAA), I have certain rights to privacy regarding my protected health information. 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 that treatment, directly and indirectly.
  + Obtain payment from third-party payers.
  + Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received and read your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 the time 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.

|  |
| --- |
|  |

**Relationship to the patient:**

|  |
| --- |
|  |

**Name IF NOT the patient:**

|  |
| --- |
|  |

**PATIENT SIGNATURE**