

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability Act of 1998 (HIPAA), I have certain rights regarding my protected health information. I understand that the 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 that treatment directly and indirectly
- ! Obtain payment from third-party payers
- ! Conduct normal healthcare operations, such as quality assessments and physician 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 has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above mentioned address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my 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 are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature : _____

Date: _____