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 (HIPPA), 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 providers who may be involved in that treatment directly and indirectly.
2. Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand 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.*

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 agree then you are bound to abide by such restrictions.

Patient Name (print) _____ Date of Birth _____

Name and Relationship to Patient (if patient under the age of 18) _____

Address _____

_____

I authorize the release of my information to:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

How would you like us to communicate with you?

(Select your preference)

- o Home # _____May we leave a detailed message? Yes _____ No _____
- o Work # _____May we leave a detailed message? Yes _____ No _____
- o Cell # _____ May we leave a detailed message? Yes _____ No _____
- o May we send an appointment reminder via text message? Yes _____ No _____

Email _____ May we leave a detailed message? Yes _____ No _____

Signature _____ Date _____

FOR 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 _____