ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT ***

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 be will 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 certificates.**

I have received, read, and understand your *Notice of Privacy Practice* 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 address listed at bottom of *Notice of Private Practice* to obtain a current copy of the *Notice of Privacy Practice.*

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 that you are not required to agree to my requested restrictions, but you do agree you are bound to abide by such restrictions.

Patient’s Name:____

Signature: ____

If other than patient, relationship: ___________________________________

Date: ____________________________

OFFICE USE ONLY

We attempted to obtain a written acknowledgment of receipt of our *Notice of Privacy Practice*, but acknowledgment could not be obtained, because:

___ Individual refused to sign

___ Communication barriers prohibited obtaining the acknowledgment

___ An emergency situation prevented us from obtaining acknowledgment

___ Other____

Signature:____ Date: ________________________