



Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability 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 healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name or Legal Guardian: _____

Signature: _____ Date: _____

Practice Use Only:

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

Date: _____ Initials: _____ Reason: _____