NOTICE OF PRIVACY 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 for:

- 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 operation such as quality assessments and physician certifications

I have received, read and understand the Notice of Privacy Acknowledgement, and am aware that I may contact the organization at any time through the business above and obtain a current copy of the Notice of Privacy Acknowledgement for my own record.

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.

_____ _____

Patient **Relationship to Patient**

_____ _____

Signature **Date**

Staff Member Sign: _____

Office Use Only

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

Date: _____ **Initials: _____** **Reason: _____**