



**Patient Acknowledgement and Receipt of  
Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of  
Health Information**

Name \_\_\_\_\_  
Print Patient's Name

Date \_\_\_\_\_

The undersigned does hereby acknowledge that he or she has either been offered a copy and/or received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Notice of Privacy Practices is available upon request.

The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

By \_\_\_\_\_  
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By \_\_\_\_\_  
Signature of Parent/Guardian (circle one)

Valid for calendar year 2026