

**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 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 Compliance Manual is available upon request.

The undersigned 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)