Notice of Privacy Practices

Acknowledgment

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. I understanding that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among 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 certifications.

I have received, read, and understood the Notice of Privacy Practices containing a more complete description of 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 to obtain a current copy of the Notice of Private Practices.

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 agree then you are bound to abide by such restrictions.

Patients Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____