HIPAA

Acknowledgment of Receipt of Notice of Privacy Practices

♦♦♦♦ You May Refuse To Sign This Acknowledgement ♦♦♦♦

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected heath information. I understand that this information can be and will be used to:

- *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 operations such as quality assessments and physicians certifications.*

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the 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 at the address above 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then your are bound to abide by such restrictions.

Patient's name: _____

Signature: _____

If other than patient,
Relationship: _____

Date: _____

OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of *Notice of Privacy Practices, but acknowledgment could not be obtained because:*

- ☐ *Individual refused to sign*
- ☐ *Communication barriers prohibited obtaining the acknowledgment*
- ☐ *An emergency situation prevented us from obtaining acknowledgment*
- ☐ *Other*_____

Signature: _____ *Date:* _____