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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I UNDERSTAND THAT UNDER THE Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that the information may be used by my clinician for the reasons/conditions below.

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and clinician certifications.

As well, the contract that I hold with my health insurance company may require my clinician to provide revelant clinical information such as, clinical diagnosis, treatment plans and clinical summaries, and/or copies of the entire clinical record.

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 Privacy 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 request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient:_____

Signature: _____ Date: _____

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OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date: _____ Name: _____

Reason:

_____

_____