HIPAA Notice of Privacy Practices Acknowledgement

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

• Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
• Obtain payment from third party payers.
• Conduct normal health care operations such as quality assessments and professional certifications.

I have received, read, and understand your HIPAA Notice of Privacy Practices containing a more complete and detailed description of the uses and disclosures of my health information. I understand that this office has the right to change its HIPAA Notice of Privacy Practices from time to time as necessitated by changes in HIPAA. I have the right, at any time, to contact this office at the address above to obtain a current copy of their HIPAA 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 that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient name (print)_____________________________________

Relationship to patient ______________________

Signature _____________________ Date _______

____________________________________________________________________________________________

To address any special needs you may have and to assure your patient information is kept confidential please answer the following questions:

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse?   YES   NO   (please circle one)

If so, please list names below for our record:

NAME: ____________________________________ RELATIONSHIP: _______________________________ PHONE #: __________________

NAME:_____________________________________ RELATIONSHIP: _______________________________ PHONE #: ___________________

OFFICE USE ONLY

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

Reason:

Staff Initials