GOVERNMENT DICTATES FOR PRIVACY
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"). I understand that 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 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 understand your Notice Of Privacy Practices containing 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.

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 understand that you are required to provide information only to the person named below.

Persons Name ____

Relationship to Patient ____

Patient's Signature ________________________________ **Date** _______________

Office Use Only

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

Date__________ **Initials** ________