Notice of Privacy Practices Acknowledgment

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

- Inform, conduct, plan and direct my treatment and follow-up among multiple health care providers who may directly or indirectly be involved in that treatment.
- Obtain payment from insurance companies, responsible parties, or third parties.
- Conduct normal health care operations such as quality assessments through chart review, physician or therapist certification and record keeping of ongoing treatment.
- Retain such data for mandated periods by private or workers compensation insurance, or for research related purposes.

I have received, read and understand the **Notice of Privacy Practices** containing a more complete description of the uses and disclosure of my health information. I understand this company 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 this notice.

I understand that I may request, in writing, to restrict how my private information or any portion of such is to be 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 are bound to abide by such.

Patient Name: _____

Signature: _____ Date: _____

Relationship to Patient: _____

Official Use Only

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

Date: _____ Initials: _____

Reason: _____
