# Notice of Privacy Practices Acknowledgement

Patient Name: _____ Date of Birth: _____

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 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 information 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 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*. 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 requested restrictions, but if you do agree then you are bound to abide with such restrictions.

If you wish to authorize our office to discuss your health information with family members or a spouse, please list them below:

***Name:*** _____ ***Relationship:*** _____

***Home Phone:*** _____ ***Cell Phone:*** _____

***Name:*** _____ ***Relationship:*** _____

***Home Phone:*** _____ ***Cell Phone:*** _____

***Name:*** _____ ***Relationship:*** _____

***Home Phone:*** _____ ***Cell Phone:*** _____

_____

**Patient/Guardian Signature and date**

_____

**Relationship to patient**

**OFFICE USE ONLY**

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

Reason: _____

Staff Initials and Date: _____

Reviewed 10/9/23