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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act (HIPPA) 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 acknowlegde that I can request a copy of this organizations 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 infornation is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that this organization agrees and is bound to abide by such restrictions.

☐ * **I have read the above conditions and agree to the terms listed above.**

By entering my initials I am authorizing them to used as my electronic signature for this form.

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Relationship to Patient:

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Response Date: _____