Notice of HIPAA 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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment, including from third-party payers.
- Conduct 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*, including for information held prior to the effective change. I understand that I may request in writing that you restrict how my health information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are generally not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions. I also understand I have the option to pay for a health care service personally and not have such claim submitted to a health plan. <u>To choose this option, I and/or the Patient must notify your Business Office and must pay the bill for that health care service in full.</u>

Patient Name: ____

Signature: ____

Relationship to Patient: ________________________________ Date: ______________________

To address any special needs you may have and to confirm your wishes, please answer the following questions:

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? Please check: ☐ YES ☐ NO

If **YES**, please list names below for our record.

Name: __________________________________ Relationship: ______________ Phone: ___________________

Name: __________________________________ Relationship: ______________ Phone: ___________________

Name: __________________________________ Relationship: ______________ Phone: ___________________

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:

Reason: ____

Staff Initials: _______________________ Date: _______________________