NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (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 or indirectly.
- Obtain payment from third parties
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received this Notice of Privacy Practices. 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 to obtain a current copy of Notice of Privacy Practices.
I understand that I may request in writing that this organization restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if this organization does agree then you are bound to abide by such restrictions.

Patient/Guardian signature:_____

Relationship to patient: _____

Printed name: _____

Date: _____

## PROTECTED HEALTH INFORMATION

I, _____ do hereby give the following person(s) access to discuss or obtain all information regarding my protected health information.

| NAME | PHONE | RELATIONSHIP |
|---|---|---|
| | | |
| | | |
| | | |

I do not wish to share my protected health information (Initial) _____