

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign acknowledgement, if you wish.

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I understand that, under the Health insurance and Accountability Act of 1998 (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 am,ong 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 phyicians certifications.

I acknowledge that I have received and read 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 from time to time and that I may contact this organization at any time 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 information is used 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 by such restrictions.

I acknowledge that I have received a copy of this office’s Notice of Privacy Practices.

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Please Print Your Name Here

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Signature

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Date

HIPPA Consent for Use/Disclosure of Health Information

This form does not constitute legal advice and covers only federal, not state, laws.