Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received 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 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 effective January 1, 2011 any third party that will request for my medical records will be charged $25 for the first 10 pages, and $.50/per page after.

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 that you are not required to agree to my requested restrictions.

Patient Name ____
Patient/Guardian Signature______________________________________
Authorized Person(s)* ____
Relationship to Patient ____
Date____
*Any individuals listed here will be authorized to receive lab results, appointment reminders, diagnosis, treatments records etc.

Office Use Only:

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

Date: ____
Employee: _______________________________________
Reason: ____

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