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NOTICE OF PRIVACY PRACTICES CONSENT AND 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 from third-party payers**
- ❖ **Conduct normal healthcare operations such as quality assessments and physicians 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* 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 information is used or 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 authorize you to release my information to: _____
(Spouse, guardian, etc)

Patient Name: _____ **Date:** / /

X _____
Signature of patient (or parent/guardian if minor)