Notice of Privacy Practices Acknowledgement:

I understand that under the Health Insurance Portability & 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 maybe involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal 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 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.

Patient name:	
Relationship to Patient:	
Signature (Patient) or (Guardian):	
Date:	