

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

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

- Coordinate my care with those providers who are involved in my treatment either directly or indirectly.
- File reports with public health and safety organizations.
- Conduct research activities.
- Respond to workers' compensation, law enforcement or other government requests.
- Conduct routine healthcare operations such as quality assessments, business procedures and physician certifications.

I acknowledge that I have read, reviewed, and understand your Notice of Privacy Practices and description of uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices over time. I may contact this organization 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 that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I have the right to: obtain a copy of my medical record, request how we communicate with you, obtain a copy of this privacy notice, choose someone to act for you if you are unable to make decisions on your own.

**My preferred contact method: (Please Check One)**

Cell Phone

Home Phone

**Preferred Contact:**

If you would like to your information regarding your medical condition and diagnosis, access to medical records, prescription pick-up and appointment scheduling with another person, please indicate below:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Consent to HIPAA Policy:**

Patient Name: \_\_\_\_\_

Relationship to Patient (if patient is a minor or unable to sign): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_