



HIPAA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change; if we change our notice you may request a revised copy by contacting our office or you will receive a new notice the next time you are treated at our office.

The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996. (HIPAA)

The patient understands that:

- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
• Protected health information may be disclosed or used for treatment, payment, or health care operations.
• The practice reserves the right to change the notice of privacy practices.

Please list names of individuals that we may talk to about your treatment. Please note this does not allow these individuals to obtain copies without a complete and valid authorization from the patient.

Two horizontal lines for listing names of individuals.

I acknowledge receipt of the Notice of Privacy Practices.

Printed Name of Patient or Representative

Signature

Date

Relationship to Patient (if other than patient)

Check if patient refused to take a copy of the Notice of Privacy Practices

State reason for refusal, if known: [Empty box]

Witness Printed Name- Practice Representative

Witness Signature

Date