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 that this information can and will be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. 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 practice 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 private practices.

I understand that I may request in writing that you reprint 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 but if you do agree then you are bound to abide by such restrictions.

Patient
Name____

Signature of Parent
Or Guardian____

Your Relationship to the
Patient____

Date____

OFFICE USE ONLY

I attempted to get the patient's signature in acknowledgement on this notice of privacy practices acknowledgement, but was unable to do so as documented below:

Date:____________________ Initials:____________________ Reason:____________________