NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Portability & Accountability Act of 1996 (HIPPA), I have certain rights of 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 parties**
- **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 it's *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 Private 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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by my restrictions.

Patient's Name: _____

Parent/Guardian Signature: _____

Relationship to Patient: _____

Date: _____

Office Use Only

I attempted to obtain the necessary signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement,* but was unable to do as documented below.

Date: _____ **Initials:** _____ **Reason:** _____