Pasadena Podiatry Group, A.P.C.

FOOT DOCTOR USA

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NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain right 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 may be involved in that treatment directly or 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 the 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 Practice.*

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 bond to abide by such restrictions.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

DATE:	INITIALS:	REASON:

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below: