Zaccagnini Medical Associates, PC (the "Practice", "ZMA")

Acknowledgement of Receipt of Notice of Privacy Practices

In general, any information that is about your health, the healthcare you receive, or payment for that care is considered confidential and protected by our Practice. We may need to use your protected health information to carry out treatment, payment, healthcare operations and/or other purposes. Our Notice of Privacy Practices provides a more complete description of permitted uses and disclosures.

Sign below to acknowledge you have received a copy of our Notice of Privacy Practices.

_____ _____

Signature of Patient or Patient's Representative **Date**

Printed Name of Patient's Representative: _____

Relationship to Patient: _____

*Return this acknowledgement as soon as possible in person or mail to our office address.

Practice Representative Only:

A good faith effort was made to obtain written acknowledgement of receipt of our Notice Of Privacy Procedures that was provided to the Patient/Patient's Representative on ____/_____/_____.

*A signature on the acknowledgement was not obtained for the following reason(s):*_____

_____

Signature Of Practice Representative: _____

I authorize ZMA to release to, or discuss with, _____, (relationship)_____ at (phone #)_____,my Protected Health Information, including if ZMA is unable to reach me despite reasonable efforts.

Signature_____**Date:**_____

I have read, understand and agree to abide by the office policies. I understand that Zaccagnini Medical Associates has the right to terminate the working relationship with patients who violate our office policies. I also acknowledge that I have read and understand the Notice of Privacy Practices and that a copy of this policy is available to me upon my request.

Patient or Responsible Party: _____

Date: _____