PINNACLE
RHEUMATOLOGY

HIPAA ACKNOWLEDGEMENT

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By signing this acknowledgment, I authorize Pinnacle Rheumatology to use and disclose my protected health information for:
- Treatment – including direct or indirect treatment by other healthcare providers involved in my care.
- Payment – to bill me directly for services rendered, and, if I choose, to provide me with documentation that I may submit to an insurance company or other payer for potential reimbursement.
- Healthcare Operations – the day-to-day administrative and clinical operations of the practice.

I have been offered a copy of Pinnacle Rheumatology's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my PHI and my rights under HIPAA. I understand that Pinnacle Rheumatology may change the terms of this Notice as permitted by law, and that I may contact the practice at any time to obtain the most current version.

I understand that I have the right to request restrictions on how my PHI is used or disclosed for treatment, payment, and healthcare operations, but that the practice is not required to agree to such restrictions. If the practice does agree, it is bound by that agreement.

I understand that I may revoke this acknowledgment, in writing, at any time. However, any use or disclosure that occurred prior to my revocation is not affected.

I have reviewed this HIPAA Acknowledgement, asked any questions I may have, and agree to follow its terms

Patient or Parent/Guardian Name _____

Patient/Parent/Guardian Signature _____ Date _____

Relationship (if not patient): ☐ Parent/Guardian ☐ Legal Representative ☐ Other: _____