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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & 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:

- 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 payers such as Medicare/Medicaid and private insurances.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I have had the opportunity to review and receive a copy of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this Clinic has the right to change its Notice of Privacy Practices from time to time and that I may contact the Clinic at any time at the address above to obtain a current copy of the Notice.

I understand that I may request in writing that you restrict how my private information is used and 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 bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Date: _____