

Notice of Privacy Practices Patient Acknowledgement

I have received the Privacy Practices for Kick Some Mass, LLC, Jeffrey Ruterbusch, D.O. in written in plain language. I understand that this same Notice also applies to any treatment or care rendered. This Notice provides the uses and disclosures of my protected health information that may be made, my individual rights, and the practice's legal duties with respect to my protected health information.

The practice reserves the right to change the terms of its Notice of Privacy Practices to remain in compliance with the governing laws and regulations and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice upon request.

Signing this acknowledgement does not mean that I have agreed to any special uses or disclosures of your health records. Refusing to sign the acknowledgment does not prevent the practice from using or disclosing health information as the Rule permits it to do. If you refuse to sign this acknowledgment, the practice must keep a records that they failed to obtain your acknowledgement.

Patient Signature

Date Signed

Relationship to patient: _____

(If signed by a personal representative of patient)

Patient Name: _____

DOB: _____