**Acton Psychological Associates, LLC**

**532 Great Road**

**Acton, Massachusetts 01720-3415**

**Office: 978.263.1972**

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

**I understand that under the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), 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 directly and indirectly**
* **Obtain payment from third-party payers**
* **Conduct normal healthcare operations such as quality assessments and physician certification.**

**I have received, read, and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health insurance. I understand that this 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 the *Notice of Privacy Practices.***

**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 bound to abide by such restrictions.**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_**

**OFFICE USE ONLY**

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