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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand the Health insurance Portability & Accountability Act of 1996("HIPPA") I have certain rights to privacy regarding my protected health information (PHI). 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 the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I received read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. 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 to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name or Legal Guardian: _____

Signature: _____

Date: _____

PRACTICE 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:

Date:	Initials:	Reason: