PATIENT HIPAA ACKNOWLEDGEMENT

Patient Name _____ **Date of Birth** _____/_____/_____
mmddyy

_____ (Patient initials) **Notice of Privacy Practice.** I acknowledge that I have received the practice's Notice of Privacy Practice, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the office if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information.** I hereby permit the practice and the physicians or other health professionals involved in my care to release healthcare information for the purposes of treatment, payment, or healthcare operations, or as allowed by law.

Patient or Responsible Person Signature _____ **Date** _____/_____/_____
mmddyy