Acknowledgement of Privacy Practices (HIPAA)

Patient Name: _____ DOB: _____ Date: _____

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices (HIPAA). I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

_____

Patient, Parent, or Guardian Signature