NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND PATIENT CONSENT FORM

ZBIGNIEW MOSZCZYNSKI, M.D., F.A.C.S.

31 West 8th Street
BAYONNE, NJ 07002

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

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 addresses above to obtain a current copy of 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient's Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____

OFFICE USE ONLY

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

Date: _____ Reason: _____ Initials: _____