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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and 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 multiple healthcare providers that may be involved in my treatment directly and/or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice or Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice from time to time and that I may contact them at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may also request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions. I understand that request to forward my medical records to another treating physician other than my primary care physician must be made in writing.

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

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

Date \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE SIGN XRAY ACKNOWLEDGMENT ON REVERSE SIDE**