HIPAA Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1966, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from designated third party payers.
3. Conduct normal healthcare operations such as quality assessments or evaluations and physician certifications.

I have been informed by you or your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information, and a copy is available from this office. 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 from time to time and that may contact this organization at any time to obtain a current copy of the notice. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand the organization is not required to agree to my requested restrictions. I understand that I may revoke this consent in writing at any time except to the extent that the organization has taken action relying on this consent.

Printed Patient Name: _____ DOB: _____

Patient/Guardian Signature_____ Date: _____