HIPPA ACKNOWLEDGEMENT FORM

I understand that, under the Heath Insurance Portability & Accountability Act of 1996 (HIPPA), 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 care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

*Obtain payment from designated third party payers.

*Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed that a written copy of your Notice of Privacy Practices is available for review in your waiting room and that copies are available upon request. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this office has the right to change it's Notice of Privacy Practices and I will be made aware of these changes as they occur.

I understand that I may request in writing that this office restrict how my information is used or disclosed. I may also choose to revoke this consent in writing at any time, except to the extent that this office has taken action relying on this consent.

Patient Name (Print) ____

Signature _______________________________ Date ________________

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy Practices from this patient, but it could not be obtained because:

Employee Signature _______________________ *Date* _________________

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