Notice of Privacy Practices
Patient Acknowledgement

Patient's name_____ **D.O.B**_____

I have received and understand this practice's Notice of Privacy Practices written in plain language. This notice provides in detail the uses and disclosures of my protected health information that may be by this proactive, my individual rights and the practice's legal duties with respect to my protected health information. This includes, but not limited to:

- A statement that this practice is requires by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make each of the following: treatment, payment and health care operations.
- A description of uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.

My individual rights with respected to protected health information and a brief description of how I may exercise these rights in relation to:

- The right to receive confidential communications of protected health information.
- The right to amend protected health information.
- The right to inspect and copy protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this Notice of Privacy Practices from the practice upon request.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree a requested restriction.
- The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.

This practice reserves the right to change the terms of its Notice of Privacy Practices and make new provisions effective for all protected health information that it maintains. If changes occur, the practice will provide me a revised Notice of Privacy Practices upon request.

Date_____ **Signature**_____

Relationship to patient (if signed by personal representive of patient)_____