

NOTICE OF PRIVACY ACT 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 the multiple health care providers who may be involved in that treatment directly 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 of 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 of Privacy Practices** from time to time and that I may contact the organization at any time 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 and disclosed to carry out treatment, payment, or health care operations. I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____

CONFIDENTIALITY AGREEMENT

Please list all persons and phone numbers with which we may give information regarding your medical care and/or treatment: _____

May we leave a confidential message on an answering machine or voice mail?

Yes _____ No _____

May we contact you or leave a message at your place of employment?

Yes _____ No _____ Phone# _____

Signature: _____ Date: _____