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## **PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT FORM FOR PATIENT**

I understand that under the Health Insurance Portability & 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, but it is not mandatory for me to sign in order to:

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

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above 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 or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bonded to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have taken action relying on this consent.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

DOB \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

DATE \_\_\_\_\_