Consent for Use and Disclosure of Health Information

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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 to:

- ❑ Conduct, plan and direct my treatment and follow-up care among 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 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 the office has the right to change its privacy policies and that I may contact the office at any time to obtain a current copy of the notice.

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 health care operations. I also understand that you are not required to agree to my restrictions, but if you do agree then you are bound to abide by those restrictions. We may decline to treat you at any time if agreement is not signed or revoked.

Patient name ______________________________ Birthdate ______________

Signature ______________________________ Date ______________

Relationship to patient(if minor) ______________________________

Office use only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials	Reason: