PRIVACY STATEMENT

I ____ understand that under the

Health 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 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 physicians certification.

I have received, read and understood 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 this 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 or disclosed to carryout treatment , payment or health care operations. I also understand you are not required to agree to my request restrictions but if you do agree, then you are bound to abide by such restrictions.

Patient Signature: __________________________

Guardian Signature: __________________________ Relationship to Patient:_____________________

Date: mo____/ da_______/ yr2014

Office Use Only

I attempted to obtain the patients signature in acknowledgement of this Notice of Health Insurance Practices Acknowledgment, but was unable to do so for the reason(s) documented below.

Date:_________Intials:________Reasons:____

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RE 7/14