NOTICES OF PRIVACY PRACTICES ACKNOWLEDGEMENT
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I understand that, under the Health 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 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 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 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: ______________________________________
(name of authorized person)
Signature: ____

If you would like anyone other than yourself to pick up written prescriptions, referral forms, or to receive your lab results, please sign below and list the persons to receive the above information.

Signature: ____
Name of Persons: ____
Date: ____