Notice Of Privacy Practices 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 healthcare providers who may be involved in that treatment direct or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as reminders of appointments for continuing or follow up care.

Please mark the boxes that we can contact you by:

___Home Email ___Work Email

___Cell Phone ___Home Phone ___Work Phone

___All Of The Above

Please name people who may have all or some of the chart info:

All of info	Some of Info

Patients Name _____
Relationship to patient _____
Signature _____
Date _____