

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- *Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- * Obtaining payment from third party payers
- * The day to day healthcare operations of our practice

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature

Date