ACKNOWLEDGEMENT FORM

I acknowledge that I have been given a copy of the Practice's "HIPAA Privacy Policy Notice", which describes the Practice's obligations to ensure the privacy of my health information. The HIPAA Privacy Notice also describes how Practice may use and disclose my health information for treatment, payment and healthcare operations. I know that I have the right to review the Practice's HIPPA Privacy Notice and to ask questions about it. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of its HIPAA Privacy Notice.

I further acknowledge that the Practice can change its HIPAA Privacy Notice in the future and that I can receive a copy of the Practice's current Privacy Notice at anytime.

I understand that I have the right to request that the Practice restrict its uses and disclosures of my health information of treatment, payment or healthcare operations. If my restrictions are accepted by the Practice, these restrictions will be binding on the Practice. I also understand that the Practice is not required to agree to my requested restrictions.

I do not request any restrictions on the Practice's use and disclosure of my health information for treatment, payment and healthcare operations. _____ (Initial)

By signing this form, I consent to the Practice's use and disclosure of my health information for treatment, payment and healthcare operations. I understand that I have the right to revoke this consent at anytime in writing, but if I do, my revocation will not have an effect on any actions the Practice has already taken in reliance of this consent.

_____ _____

Signature of Patient/Guardian Date

[ ] patient chose not to sign acknowledgement

Reason: _____

_____

Office staff acknowledge patients refusal to sign consent.