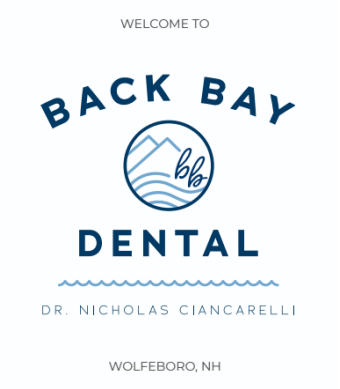


**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

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 be used to:

Conduct, plan and direct my treatment and follow-up among the 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 it's Notice of Privacy Practices from time to 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 carry out treatment, payment, or health care restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

**Official Use Only**

I attempted to obtain the patient's signature in acknowledgement on this **Notice of Privacy Practice Acknowledgement** but was unable to do so as documented.