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Acknowledgment of Receipt of Notice of Privacy Practices

This document discusses how your confidential information is handled. In order to provide effective treatment for my patients I may need to consult with other treatment providers, to obtain authorization for treatment from insurance companies or other payors, and to work with office staff members or business associates, such as accounting or billing services.

This office will provide you with its Notice of Privacy Practices, a written description of how the office handles "protected health information" (PHI) about you. The Notice describes how this office protects, uses, and discloses health information, and your rights regarding your protected health information. Prior to signing this Acknowledgment you have the right to receive and review the Notice of Privacy Practices.

Your PHI may include information created and received by this office, which may be in the form of written or electronic records or spoken words, and may include information about your history, health, diagnoses, symptoms, medications, examinations, test results, treatments, and other types of health-related information. By signing this Acknowledgment you agree that this office may use and disclose your health information in order to:

• Make decisions about and plan for your care and treatment

• Refer, consult, and coordinate with other health care providers for your treatment

• Determine your eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or other payors

• Perform office, administrative, and business functions in order to provide you with and be reimbursed for professional services

The Notice of Privacy Practices may be revised from time to time, and you are entitled to receive a copy of the revised Notice. A copy or a summary of the current version of the Notice of Privacy Practices in effect will be available in the office.

I understand I have the right to ask that my PHI not be disclosed or used as described in the Notice of Privacy Practices, but that my provider is not required by law to agree to such requests. This acknowledgment may be revoked in writing, but not retroactively. By signing below, I agree that I have reviewed and understand the information above and have received a copy of the Notice of Privacy Practices.

Patient/Representative:_____ Date:_____

Witness:_____ Date:_____