NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patients Name:____Date of Birth ______________

I understand that, under The Health Insurance Portability Accountability of 1996, I have certain rights to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practices.

The practice reserves the right to change the terms of its Notice of Privacy Practices. I understand the Practice will provide current Notice of Privacy Practices on request.

Signature:____________________________________

Relationship:__________________________________

Date:____

For office use only.

I was unable to obtain the patients signature.

Date__________________ Name____

Reason____

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