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HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Health Insurance Portability and Accountability Act (HIPAA) require our office to make available to me a Notice of Privacy Practices that explains my rights regarding the privacy and confidentiality of my patient health information. I have received this notice and am aware that any questions regarding this notice should be directed to the Privacy Office:

Print Name: _____
(Patient Name)

Signature: _____
(Patient or Responsible Party Signature)

Relationship to Patient: _____ Date: _____

With understanding the new HIPAA laws, I do realize that my health information cannot be shared with family members and or friends without my written consent. In understanding this, I would like my information to be shared with the following people:

_____ _____
Name / Relationship / Phone Number Name / Relationship / Phone Number

_____ _____
Name / Relationship / Phone Number Name / Relationship / Phone Number

Signature: _____ Date: _____