Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand that his information can and will be used to...

* Conduct, plan, and direct my treatment and follow-up among 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.

Effective April 14, 2003, due to federal regulations HIPAA, we are required to have a release form signed by the patient before we can give out any medical or financial information to any person other than the patient.

Please list below the names, relationships, and phone numbers of any authorized individuals with whom we may discuss your medical or financial information.

NAME	RELATIONSHIP	PHONE	OK/FINANCIAL	OK/MEDICAL
1.				
2.				
3.				

If we cannot reach you may we leave medical or financial information on:

Home Answering Machine:	YES	NO
Work Voice Mail:	YES	NO
Cell Phone:	YES	NO

_____ _____
Signature of Patient/Parent Date

IF YOU DO NOT WANT ANY MEDICAL OR FINANCIAL INFORMATION DISCUSSED WITH ANYONE OTHER THAN YOURSELF, PLEASE SIGN HERE.

_____ _____
Signature of Patient/Parent Date

OFFICE USE ONLY

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

_____ _____