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.

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

Signature: _____

Relationship: _____
Date: _____

I was unable to obtain the patients signature

Date_____ Name_____