HIPAA PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge receipt of:

- **HIPAA "Privacy Notice"**

The person or persons completing my registration process have explained to me that:
I need to read the information contained in these documents, and ask my healthcare staff if I need assistance in understanding my rights, or if I would like them to explain these materials to me in more detail.

I have been told:

- **That these materials are to inform me of my privacy rights as a patient**
- **That the HIPAA "Privacy Notice" I have been given states that my personal "protected health information" (PHI) will be used and disclosed by my doctor and his staff in the routine activities of treatment, payment and healthcare operations.**
- **Before any other use or disclosure of my personal protected health information is made I will be asked for my written authorization.**

I have been told that I have the right:

- **To CONFIDENTIAL COMMUNICATIONS**
- **To REQUEST RESTRICTIONS on Uses and Disclosures of my PHI**
- **To REQUEST ACCESS my personal protected health information**
- **To REQUEST AMENDMENTS to my personal protected health information**
- **To have an ACCOUNTING of any DISCLOSURES for purposes other than of treatment, payment and healthcare operations**

______ I am requesting restrictions on uses and disclosures as noted below:

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PATIENT/REPRESENTATIVE SIGNATURE: ___________________________________

DATE: ______________

PRINT PATIENT NAME: ____

RELATIONSHIP: _________ SELF _________OTHER:_____________________________

THIS ACKNOWLEDGEMENT EXPIRES SEVEN YEARS FROM THE DATE OF THE SIGNATURE ABOVE