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# Notice Of Privacy Practice

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 this information can and will be used to:

- Conduct, plan, and directly treat and follow-up among the multiple health care providers who may be involved directly and indirectly with treatment.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your notice of privacy practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its notice of privacy practices from time to time and that I may contact this organization at any time at the above address to receive a current copy of the notice of privacy practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Printed): _____

Patient/ Guardian Signature: _____

Date: _____ Relationship to Patient: _____

Witness: _____