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ACKNOWLEDGEMENT AND CONSENT
HIPPA Notice of Privacy Practices

I _____(print name) understand my health information may include information both created and received by the practice and may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatment, procedures, prescriptions and similar types of health related information.

I understand and agree this practice may use and disclose my health information in order to:

1. Make decisions about and plan for my care and treatment
2. Refer to, consult with, coordinate among and manage along with other healthcare providers for my care and treatment
3. Determine my eligibility for health plan or insurance coverage and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or the entirety of my healthcare costs.
4. Perform various office administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality cost-effective healthcare.

I also understand I have the right to receive and review a written description of how this practice will handle health information about me. This written description is known as the **HIPPA Notice of Privacy Practices** and describes the uses and disclosures of health information made and the protocols followed by our office personnel and my rights regarding my health information.

I understand I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the **HIPPA Notice of Privacy Practices** and I understand this practice is not required by law to agree to such requests.

By signing below, I agree I have reviewed and understand the information above

_____ _____

Patient Signature Date