

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (“PHI”) about you. You have the right to review our Notice and ask questions about our privacy practices. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by making your request orally or in writing to any staff member in our office.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by the agreement.

By signing this form you acknowledge that you have been offered a copy of our Notice of Privacy Practices, you have had the opportunity to review the copies readily available in our office, and you have the right to request a personal copy at any time.

Name of Patient (please print)

Signature of Patient

Date: _____

I have chosen not to receive a full personal copy of the Privacy Practice. _____
Initial

This form is effective April 1, 2008 and valid through March 31, 2009