

Notice of Privacy Practices Acknowledgement

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received the 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 address above to obtain a copy of the Notice of Privacy Practices. _____

I authorize that I give my permission to Dr. Ricardo and his representatives to speak with Initials _____ regarding treatment, medical and account information. I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment and health care operations.

I also understand 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: _____

Relationship to Patient: Self Other:
(Please specify what relationship to patient is.)

Signature:

Date:

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement to the Notice of Privacy Practices acknowledgement, but was unable to do so as documented below:

Initials

Date

Reason: