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**HIPAA FORM**

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information (PHI). 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 the treatment directly and indirectly.
* Obtain payment from third-Party Payers.
* Conduct normal heath operations such as quality assessments and physicians certifications.

I received, read and understand you Notice of Privacy Practices containing a more complete description of the uses and disclosures of my PHI. UI understand that this organization has the right to change Notice of Privacy Practice from time to time and that I may contact his organization at any time to obtain a current copy of the Notice of Privacy Practice.

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Patient, Parent or guardian Date

**PRACTICE USE ONLY**

I attempted to obtain the patients signature in acknowledgement of the Notice of Privacy Practice Acknowledgement but was unable to do so as documented below.

Date: Initial: Reason: