

Patient Name: _____ D.O.B.: _____ Date: _____

PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I acknowledge that I have offered a copy of the *Notice of Privacy Practices for Protected Health Information*.

Patient Signature

Authorized Provider Rep.

Personal Representative Printed

Personal Rep. Signature

Description of personal representative's authority to act for the patient