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## NOTICE OF PRIVACY PRACTICES
## RESPONSBILE PARTY ACKNOWLEDGEMENT

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 ("Hipaa"),** 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/or indirectly.**
- ***Obtain payment from third-party payers.**
- ***Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read, and understand your Notice of Privacy Practices containing a more completed description of the uses and disclosures of my health information. I understand 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 current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or 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.

**PLEASE NOTE:**

**This form is NOT a notice or acknowledgement of financial responsibility**.

**Who should fill this form out? Who is the "responsible party"**
Patients over 18 years of age who are legally responsible for their own health information, OR The legal guardian (i.e., a parent or Power of Attorney) of a patient under 18 years of age or a patient over 18 years of age who is not legally responsible for their own health information.

**Printed Name of Responsible Party:**_____
**Signature of Responsible Party:**_____
**Relationship of Responsible Party to Patient Self Parent Other**
**Today's Date**_____
**Printed Name(s) of Additional Person(s) with whom to share Health Information, and their relationship to person or patient**_____

Office use only
I was unable to obtain the Responsible Party's Signature on this Notice of Privacy Practices
Today's Date: