

Notice of Privacy Practices Acknowledgement

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Troy, MI 48098

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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 indirectly.
- Bill third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that a copy of your Notice of Privacy is available for review upon request, containing a more complete description of the uses and disclosures of my health information.

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.

Patient Name: _____

Signature of Patient (Parent if Minor): _____

Relationship to Patient (if parent): _____

Date: _____

Office use only

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

Date	Initials	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____