ACKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I understand that upon my request, I will be given the opportunity to review this office's Notice of Privacy Rights as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations.
- Provide and coordinate treatment among health care providers who may be involved in my care.

PATIENT NAME _____

SIGNATURE _____

RELATIONSHIP TO PATIENT _____

DATE _____

Dependent family members also covered by this acknowledgement.

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Rights due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other