

Acknowledgment of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (“PHI”) about you. You have the right to review our Notice and ask questions about our privacy practices. As provided in our Notice, You may obtain a revised copy by requesting one from our office.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you acknowledge that you have received our Notice of Privacy Practices.

Patient Name

Patient Signature

Date

It is acceptable to leave messages containing private medical information on my answering machine and/or cell phone.

Yes

No

Initial