Notice of Privacy Practices Acknowledgment

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/for:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers (including pharmacies/pharmacists) who may be involved in my treatment directly and indirectly.
- Obtain payment and/or payment information for services, confirming insurance coverage, and billing or collection activities. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations which include the business aspects of running our practice. Examples of this would include posting of our daily schedules throughout the office, having a sign in sheet, calling to confirm appointments, leaving messages on your voicemails to confirm appointments, sending reminder/appointment cards in the mail with our practice name on them, discuss with/allow family members/guardians into the exam process to allow for a better understanding of treatment options when necessary.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document.

When you sign this consent document, you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations as reviewed above and outlined in our Notice. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent.

As per HIPAA, we can decline to serve you if you elect not to sign this consent form.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Signature _____ Date _____

Relationship to Patient _____