

Notice of Privacy Practices

Acknowledgment of Privacy Practices

A Notice of Privacy Practices, detailing how my protected health information (PHI) may be used and disclosed under state and federal law is posted and available for my review. I understand the contents of the Notice and I request the following restriction(s) concerning the use of my protected health information.

Further, I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment benefits apply.

Patient Signature

Date

If not signed by patient, please indicate relationship to patient (i.e., parent, spouse)

Relationship to Patient