NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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Virginia Beach, VA 23462
(757) 497-2988

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that his 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
- Obtain payment from third-party payers
- Conduct normal healthcare operation such as quality assessments and physician certificates

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the above address about how to obtain a current copy of the *Notice of Privacy Practice.*

I understand that I may request in writing that you restrict how my private information is used to disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restriction.

PATIENT NAME: _____ RELATION OF PATIENT: _____

SIGNATURE: _____ DATE: _____

Please check your preferred means of communication:

□ You may contact me at my home telephone number: _____
□ You may contact me on my mobile telephone number: _____
□ You may contact me at my work telephone number: _____
□ You may send me an unencrypted email/text message at: _____
□ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added / Removed: _____
2. _____ Date Added / Removed: _____
3. _____ Date Added / Removed: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practices,* but was unable to do so as document below.

_____ _____ _____

DATE INITIALS REASON