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HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I, _____ (Patient), acknowledge that I have received and reviewed a copy of _____ (Provider/Practice)'s *Notice of Privacy Practices*. This notice describes how my protected health information (PHI) may be used and disclosed in the course of my treatment, payment, and healthcare operations, and it explains my rights regarding access to and control of this information.

I understand the following:

1. My provider or practice is required by federal law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as applicable state laws, to maintain the privacy and security of my health information.
2. My provider or practice will not use or disclose my health information without my authorization, except as described in the Notice of Privacy Practices or as otherwise permitted or required by law.
3. I have the right to request restrictions on certain uses and disclosures of my health information, to request confidential communications, and to inspect or obtain a copy of my medical record as allowed by law.
4. I may request an amendment to my health information if I believe it is incorrect or incomplete. My provider or practice will review my request and respond in accordance with the law.
5. I have the right to receive an accounting of certain disclosures of my health information made by my provider or practice in accordance with HIPAA.
6. I have the right to receive a paper copy of the Notice of Privacy Practices at any time, even if I have agreed to receive it electronically.

7. If I believe my privacy rights have been violated, I may file a complaint with my provider or practice, or directly with the Office for Civil Rights at the U.S. Department of Health and Human Services, without fear of retaliation.

By signing this acknowledgment, I confirm that I have received and reviewed the *Notice of Privacy Practices* and that I understand my rights regarding the privacy of my health information.

Patient (or Legal Representative):

Signature: _____ Date: _____

Printed Name: _____

If signed by Legal Representative, state relationship to patient: _____

Provider/Practice Representative:

Signature: _____ Date: _____ Printed

Name: _____