Notice of Privacy Practices Acknowledgement

Notice of Privacy Practices Acknowledgement I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (**HIPPA**). I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

2. Obtain payment from third-party payers.

3. Conduct normal healthcare operations, such as quality assessments and physicians certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is used to disclose to carry out treatment, payment, or healthcare operation. I also understand you are not required to agree to my requested restrictions, but if you agree, then you are bound to abide by such restrictions.

Signature: _____ Date: _____

**If patient is minor (parent/guardian signature)

Medical Information Release Form

We are unable to discuss your medical and financial information with anyone except you without written consent.

I authorize the release of information including diagnosis, records, images, examinations rendered, claims information and financial information regarding one time payments and reoccurring payment information. Please list below anyone who has the permission to any of the above information.

Name: _____ Relationship to you_____

Name: _____ Relationship to you_____

I choose not to share my information ☐ (Please check here if necessary)

Signature: _____ Date: _____

**If patient is minor (parent/guardian signature)

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