

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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:

- 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 operations such as quality assessments and physician certifications.

I acknowledge that I reviewed* your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that your organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact your office at any time to obtain a current copy of the *Notice of Privacy Practices*.

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

*A copy of our *Notice of Privacy Practices* is available on our website (www.periomaine.com) and is posted in our offices. You can obtain a copy by contacting our office.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

DATE: _____