IMPORTANT NOTICE TO OUR PATIENTS

Patient Name: _____Admission Date:_____

As required by HIPAA, all Patients who receive health care services must:

1. **Receive** or at least be offered the attached "Notice of Privacy Practices" Form; and

2. **Sign** the "Acknowledgement" Form below and return it for our records.

Please note that the attached Notice is not a consent form that must be read in full and signed before treatment can be provided; rather, the Notice provides our Patients with a summary description of (1) how our office will use and disclose medical and billing information for legitimate business purposes, and (2) how our Patients can exercise their rights with regard to this medical information. These notices are similar to the ones that the general public received from their banks and other financial institutions.

Please Sign the Acknowledgement Form below and return it for our records.

Thank you very much.

ACKNOWLEDGMENT FORM

I hereby acknowledge that I have received (or was at least offered) a current copy of Provider's Privacy Notice.

_____ _____

Patient or Personal Representative* Signature Date

(*) If signed by Personal Representative, please state your relationship to Patient:

_____

Revised 09/13
HIPAA Acknowledgment Form

White Copy – Chart; Yellow Copy - Patient