Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name: _____ DOB: _____
(Please Print)

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Date: _____

By: _____
Patient's Signature

If patient is a minor or under a guardianship order as defined by State law:

By: _____
Signature of Parent/Guardian (circle one)

Please list the people that we may discuss your condition with and their relation to you:

_____

_____

_____