Notice Of "HIPAA" Acknowledgement & Patient Authorization Form

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:

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 physician certifications.

I hereby authorize you to use or disclose my healthcare information as described in the "HIPAA" form without contacting me unless it's an outside party and I may add or take off a person at any time. I understand that:

1. I may inspect or copy the protected health information to be used or disclosed.
2. I may revoke this authorization in writing by contacting your office by address, attention Privacy Officer.
3. Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
4. I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide me that treatment).

I have received, read and understand your *HIPAA Acknowledgement* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *HIPAA Acknowledgement* from time to time and that I may contact this organization at any time by address to obtain a current copy of the *HIPAA Acknowledgement*.

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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________