NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have read the foregoing and received a copy of the "Notice of Privacy Practices" that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I authorize _____ to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to _____ any information obtained in the adjudication of any claim for services furnished to me by _____.
- I acknowledge that _____, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

_____ _____
Printed Name of Patient Date of Birth

_____ _____
Signature of Patient/Guardian Date

_____ _____
Printed Name of Guardian Relationship to Patient

FOR INTERNAL USE ONLY

_____ _____
Name of Employee Signature of Employee

- ☐ If applicable, reason patient's written acknowledgment could not be obtained:
- ☐ Patient was unable to sign.
- ☐ Patient refused to sign.
- ☐ Other:_____