



## Privacy Policy Acknowledgement

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I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

I give permission for the following person/people to have full disclosure of my appointments and/or medical records:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_