



**NOTICE OF PRIVACY PRACTICES  
PATIENT ACKNOWLEDGEMENT FORM**

Your privacy, including the confidentiality of your health information, is very important to us. Additionally, Federal law prohibits the unauthorized release of certain medical and health information. Before our office can use your Protected Health Information for treatment, payment, and health care operations, you must acknowledge that you have received a copy of our Notice of Privacy Practices informing you how our office may use and disclose your Protected Health Information.

You should carefully read our Notice of Privacy Practices to understand how we take steps to protect the privacy and confidentiality of your Protected Health Information. Federal law gives you certain rights regarding the use and disclosure of your Protected Health Information. These rights include: (1) the right to request that we restrict how your Protected Health Information can be used or disclosed for treatment, payment, or health care operations; (2) the right to receive confidential communications for your Protected Health Information, if applicable; (3) the right to inspect and copy your Protected Health Information; (4) the right to amend your Protected Health Information; and (5) the right to receive an accounting of the disclosures of your Protected Health Information.

To respect your privacy, please tell us which of the following numbers we should call to communicate with you regarding Appointment Reminders, Lab Results, etc. **Only list the phone number or numbers you want us to call.**

Home _____	May we leave a message?	___ Yes ___ No
Work _____	May we leave a message?	___ Yes ___ No
Cell Phone _____	May we leave a message?	___ Yes ___ No
Other _____	May we leave a message?	___ Yes ___ No

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Print Name of Patient/Legal Representative

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Signature

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Date