Health Insurance Portability & Accountability Act of 1996
(HIPAA)

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:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this provider has the right to change his Notice of Privacy Practices from time to time and that I may contact this provider at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that this provider restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand this provider is not required to agree to my requested restrictions, but if he does agree then he is bound to abide by such restrictions.

Patient Name: ____________________________________________

Legal Guardian (If patient is a minor): ____________________________

Signature: ___________________________________________________

Date: ______________

__________________________________________________________________________

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so as documented below:

Date: ______________ Provider: __________________________________________

Mailing Address: P.O. Box 357504, Gainesville, FL 32635