**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

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 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 customer service.

I have received, read, and understand your Notice of Privacy Practices concerning a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization to obtain a current copy of the Notice of Privacy Practices.

**FOR THE PRIVACY OF OUR PATIENTS AND STAFF, WE ASK THAT NO VIDEOS OR PHOTOS BE TAKEN IN OUR OFFICE. THANK YOU FOR YOUR COOPERATION.**

PATIENT NAME (PRINTED): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PARENT OR LEGAL GUARDIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_