

# DAVIDSON FAMILY MEDICINE, P.A.

## 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 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 certification.

I have been given the opportunity to read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice Of Privacy Practices from time to time and that I may contact this organization at any time at the address shown to obtain a current copy of the Notice of Privacy Practices.

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

In regard to such restrictions, unless I specify in writing otherwise, I understand that routine appointment reminder calls will be made to the home phone number I have listed on my new patient information sheet. I further understand that messages will be left at that number to return calls to this office.

Patient Name \_\_\_\_\_

Signature \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Date \_\_\_\_\_