ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES

I have reviewed this office's information from HIPAA regarding my **Rights to Privacy,** which explains how my medical and financial information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I understand that I have already given this office permission to release this information on a need to know basis to my insurance carrier and/or to consulting physicians or specialists.

Signature of Patient/Guardian Date

If you want any other person or persons to have access to your medical and financial records on your behalf, list their name/names and their relationship to you below. For example, this could be your spouse, mother, sister, or friend.

Name of Person/Persons Date

This can be changed at any time by the above patient or their legal guardian.