

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

## DR. JOHN R. SIMPSON

I understand that, under Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 acknowledge that I have received your Notice of Privacy practices, or is readily available, containing 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 from time to time and that I may contact this organization at any time at the address above 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 then you are bound to abide by such restrictions.

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

**Relationship to Patient** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_