

Patient Acknowledgement and Receipt of Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

Name _____ Date _____
(Print Patient's Name)

The undersigned does hereby acknowledge that he or she has been offered a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA compliance Manual, State Law and Federal Law.

Date ____/____/____

By _____
(Patient's Signature)

If patient is a minor or under a guardianship order as defined by State Law

By _____
(Signature of Patient Guardian)