

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

Name \_\_\_\_\_ (Print Patient's Name)    Date \_\_\_\_\_

The undersigned does hereby acknowledge that he or she has received 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 undersign does herby 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 Manuel, State Law and Federal Law.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

By \_\_\_\_\_ (Patient's Signature)

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

By \_\_\_\_\_ (Signature of Parent/Guardian)