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

Patient's Name (printed): _____ 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 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 HIPPA Compliance Manual, State Law and Federal Law.

Today's Date: _____

Patient Signature: _____

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

Parent/Guardian Signature: _____