



Attachment 9: Privacy Practices Acknowledgement

The notice of Privacy Practice describes how medical information about you may be used and disclosed and how you can get access to the information.

PLEASE, REVIEW IT CAREFULLY, AS IT EXPLAINS:

- **How this office will use and disclose your protected health information.**
- **Your privacy rights with regard to your protected health information.**
- **This office's obligations concerning the use and disclosure of your protected health information.**

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practices is available at the front desk upon request. I also acknowledge that I have received a copy and understand the Patient Rights and Responsibilities.

PATIENT NAME: _____ DOB: _____

Print Patient/Member Name: _____

Signature: _____ Date: _____

Print Name of Person Signing (if other than the patient/member):

Signature: _____ Date: _____