Not a NY Article 28

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE AND CONSENT TO USE AND DISCLOSURE FOR TREATMENT, PAYMENT AND OPERATIONS PURPOSES

By signing below, I hereby acknowledge that I have been provided the opportunity to obtain a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. It is posted in the waiting room and available for copy on request. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office. I understand that I may refuse to sign this authorization. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on signing an authorization in writing at any time. If I do, it will not affect any previous actions already taken in reliance upon my authorization. I may revoke this authorization by writing a letter and mailing it by certified mail, return receipt requested to the Privacy Officer at the health care provider listed above.

Once health information is disclosed pursuant to this authorization, it may be re-disclosed and may no longer be protected by privacy laws.

Signature of Patient or Legal Representative

Printed Name of Patient or Legal Representative

Date

HIPAA Acknowledgement