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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and in indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that the North Port Podiatry Center has the right to change its Notice of Privacy Practices from time to time and that I may contact the North Port Podiatry Center at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you further restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required by law to agree to my requested additional restrictions, but if you do agree then you are bound to abide by such additional restrictions.

PATIENT NAME \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_