Boca OB/GYN

TopLine MD Alliance

I understand that, under the Health insurance Portability.& Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information- I understand that this information can and will be used to: t ' Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. o 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 this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of private Practices. I understand that I may request in writing that you 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 to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name : _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY I attempted to obtain the patient's signature in acknowledgement on this Notice of privacy practices Acknowledgement, but was unable to do so as documented below:

Date:_____**Initials:**_____**Reason:**_____