Lona Sasser, D.O. LLC

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have the right 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 indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment 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 Privacy Practices.*

I understand my request that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations must be in writing. I also understand you are not required to agree to my requested restrictions, but if you do agree, 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 to this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

PLEASE FILL OUT THE BACK OF THE FORM→

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Patients' rights of disclosures: In general, HIPAA privacy rule gives the individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communications of the health information be made by alternative means.

I, _____, wish to be contacted in the following manner:

Home:

☐ Ok to leave a detailed message

☐ Leave a message with callback number only

Cell Phone:

☐ Ok to leave a detailed message

☐ Leave a message with callback number only

Work:

☐ Ok to leave a detailed message

☐ Leave a message with callback number only

Written communication:

☐ Ok to mail to home

☐ Ok to fax to home fax # _____

☐ Ok to fax to work fax # _____

List all persons in your household who, in your absence, may make requests on your behalf; and with whom we may speak to regarding your medical information.

Name **Relationship**

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____