**Patient Acknowledgement and Receipt of**

**Notice of Privacy Practices Pursuant to HIPAA and Consent**

**For Use of Health Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Print Patient’s Name

The undersigned does hereby acknowledge that he or she has received a copy of this office’s Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office’s HIPAA Compliance Manual is available upon request.

The undersigned does hereby consent to the use of his or her Personal Health Information (PHI) in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law and Federal Law.

Dated this \_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature

If patient is a minor or under a guardianship order as defined by State Law:

By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian (circle one)