

Acknowledgement of Review of Notice of Privacy Practices

If have had the opportunity to read this office's complete Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I understand that by signing this form I consent to the following:

1. Sharing information for the purpose of treatment: You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care.
2. Sharing of information for purpose of payment: You will share all necessary information with my insurer(s), payor(s), governmental entitles (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies.
3. Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

Patient's Name (printed)

Date

Patient's Signature (or guardian, if a minor)

Relationship (if a minor)

For more detailed information, there is a complete copy of the Notice of Privacy Practices in our waiting room or you can ask the receptionist for a copy.