2421 WEST FAIDLEY AVENUE
GRAND ISLAND, NE 68803
(308) 384-2101

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain 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, insurance companies.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I was provided a copy of the Notice of Privacy Practices containing a more complete description of the use and disclosure of my health information and that I have read (or had the opportunity to read) and understand the Notice. I understand that this organization has the right to change its Notice from time to time and that I may contact this organization at any time to obtain a copy of said Notice.

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 that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by said restrictions.

Patient Name: ____ Birthdate: ______________________
(please print)

Parent or Authorized Representative (if applicable): ____
(please print)

Signature: ____ Date: __________________________

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: ____ Initials: _________________________

Reason: ____

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