Notice of Privacy Practice Acknowledgement
(HIPPA waiver)
The Family Clinic
621 Florida Avenue
Lynn Haven, Florida 32444

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights 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 payer sources.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I have received 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 that I may request in writing that you restrict how my private information is used or disclosed to arry 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 _____

I authorize the following individual _____ to have access to my personal medical information.

Signature _____

Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement, but was unable to do so as documented below.

Date _____ Initials _____ Reason _____