NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payers.

- Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practice containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practice 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 carry out treatment, payment or healthcare 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.

I understand I have the right to complain to the U.S. Department of Health and Human Services and to the IHG, at the address above, if you believe your privacy rights have been violated.

PATIENT NAME: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____   DATE: _____

**IHG MAY RELEASE INFORMATION REGARDING MY MEDICAL INFORMATION AND/OR BILLING TO THE

FOLLOWING: _____
RELATIONSHIP_____

<u>OFFICE USE ONLY</u>

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO SO AS DOCUMENTED BELOW:

DATE _____ INITIALS _____ REASONS _____

PLEASE NOTE: **You will be required to sign HIPAA consent electronically in our office at the time of your visit**