



P. O. Box 697
710 S.W. Highland Avenue
Redmond, OR 97756
(541) 923-7432

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

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 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 by such restrictions.

_____	_____
Patient Name	Date
_____	_____
Signature	Relationship to patient

OFFICE USE ONLY

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

Date	Initials	Reason
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