NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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 understand that the *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information. A copy of this is available to me at any time. I also understand that Atlantic Digestive Specialists has the right to change its Notice of Privacy Practices from time to time and that I may contact Atlantic Digestive Specialists at the address above to obtain a current copy of their *Notice of Private 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 health care operations. I also understand that if you agree to my requested restrictions, you are bound to abide by such restrictions.

Patient Name: ____
Relationship to Patient: ____
Signature: ____
Date: ____

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

Date: ________________ Initials: __________ Reasons: ____________________________

PLEASE ATTACH BLUE HIPAA LABEL TO PATIENT CHART

Form 705