Allison & Associates
15 Aviemore Drive
Pinehurst, NC 28374
(910) 295-4343

Notice of Privacy Practices Patient Acknowledgment

Patient Name:_____ Date of Birth:_____

I have received this practice's *Notice of Privacy Practices* written in plain language. The *Notice* provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its *Notice of Privacy Practices*, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current *Notice of Privacy Practices* on request.

Signature:_____
Date:_____
Relationship to patient (if signed by a personal representative of patient):
_____

Patient Consent Form

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 have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization had 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 to abide by such restrictions.**
- **I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.**
  Patient:_____
  Signature:_____
  Relationship to Patient_____
  Date:_____