Notice of Privacy Practices Acknowledgement and Consent

I understand that, under applicable laws, including the Health Insurance Portability and Accountability Act of 1996, as amended ("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.
- Verify benefits, authorize services and obtain payment from third-party payers, including any private or government insurance program that covers me, including Medicare and Medicaid.
- Conduct normal healthcare operations of Primary Care Health Partners, such as quality assessments and physician certifications.

I understand that this health information may include information concerning conditions of mental illness, substance or alcohol abuse, genetic testing, sexually transmitted diseases (including HIV/AIDS) and workers' compensation.

I have received, read and understand the *Notice of Privacy Practices* containing a more complete description of the uses of my health information. I understand that Primary Care Health Partners have the right to change the *Notice of Privacy Practices* from time to time and that I may contact this office at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that Primary Care Health Partners restrict how my health information is used or disclosed. I also understand that Primary Care Health Partners is not required to agree to my requested restrictions, but if it does agree, then Primary Care Health Partners is bound to abide by such restrictions.

The undersigned certifies that he/she has read the foregoing, is the patient or the parent or legal guardian of the patient (if the patient is a minor), or is otherwise duly authorized as the patient's agent to execute this Acknowledgement and Consent.

Patient Name:_________________________________ Date of Birth:_________________

Signature: _________________________________ Today's Date:_________________

Relationship to Patient (if not self): ____