NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996, (HIPPA), 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 received, read and understand the “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 4119 Montrose Boulevard, Suite 310, Houston, TX 77006 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 health care 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.

Client Name Printed: _____

Client Signature: _____

Date: _____