



7777 Hennessy, Suite 1008  
Baton Rouge, Louisiana

**Acknowledgement of Receipt of Notice of Privacy Practices**

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 and disclosed to:

- evaluate my health, diagnose my medical condition and provide treatment
- obtain payment from third-party payors
- conduct normal operations of our medical practice such as quality assessments, physician certifications, appointment and surgery scheduling, etc.
- fulfill other purposes which are listed in our Notice of Privacy Practice

I have received a copy of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information as well as certain rights that I have as a patient. 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 your Notice of Privacy Practices.

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Signature of Patient or Representative \_\_\_\_\_

Relationship to Patient if signed by a Personal Representative \_\_\_\_\_



**OFFICE USE ONLY**

Patient's signature was not able to be obtained for the reasons documented below:

Date: \_\_\_\_\_

Reason(s) Acknowledgment was not Obtained: \_\_\_\_\_

Name of Staff Member \_\_\_\_\_