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.
- fullfill 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) Acknowledment was not Obtained: ____

Name of Staff Member ____