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## Acknowledgment 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 to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand the *Notice of Privacy Practices* document containing a more complete description of the uses and disclosures of my health information. I understand that **John Madej, MD / Jessica Madej, MD** (“Practice”) 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 below for a current copy of the *Notice of Privacy Practices* document.

### Do we have your permission to:

Leave a message on your answering machine?

Yes  No

Confirm appointments by leaving messages or speaking with family?

Yes  No

Speak to household members concerning your care?

Yes  No

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name/relationship to patient if  
patient unable to sign

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date