HIPPA NOTICE OF PRIVACY PRACTICES

I keep medical records of the health services I provide for you. You may ask to see and to copy your records. Your records will be kept confidential unless you give me written permission to release them or if I am required to do so by law. I will ask you to sign a consent form allowing me to use and disclose your health information for the purposes of treatment, payment, and healthcare operations in the office.

May I leave a detailed message at the phone number you provided?

YES NO

If not, please provide an additional phone number_____

Would you like a paper copy of the HIPPA Notice of Privacy Practices?

YES NO Initials_____

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

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Signature of patient or legal representative Date