Magnolia Family Practice

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 **Magnolia Family 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
Leave pre-medication reminders (if applicable)?	☐ Yes	☐ No
Speak to household members concerning your care?	☐ Yes	☐ No

Patient name	Signature	Date
Name/relationship to patient	Signature	Date

Practice provided the above-referenced patient with the Practice's Notice of Privacy Practices and this Acknowledgment of Receipt of Notice of Privacy Practices, but could not obtain a signed acknowledgment form because:

☐ Patient or guardian refused to sign
☐ Emergency situation
☐ Other: _____

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