Nancy R. G. Church, M. D., L.L.C.
Notice of Privacy Practices Acknowledgement

Patient Name_____ Date of Birth_____

I understand that, under Health Insurance Portability & Accountability 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 healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my private health information. 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 to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

We will mail clinical and financial information to your home address unless otherwise instructed to use a different address on the Patient Registration Form. Please indicate how you would like us to contact you by telephone:

Primary Telephone at _____
___ Leave a message with detailed information.
___ Leave a message with a name and call back number only.

Secondary Telephone at _____
___ Leave a message with detailed information.
___ Leave a message with a name and call back number only

Preferred Pharmacy Name: _____
Pharmacy location or phone: _____

If you permit us to discuss any information with another party, please list that name below:
Name: _____
Relationship to you:_____

Signature_____Date_____
Relationship to patient: ___ self ___ parent/guardian ___ spouse/partner ___ other