



## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act (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 acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my 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 at 801 E. 66<sup>th</sup> Street, Savannah, GA 31405 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my PHI is used or disclosed to carry our 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.

Parent/ Guardian Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient(s) Name: \_\_\_\_\_  
\_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

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### Permission to Disclose

I request and allow you to share medical/dental information regarding my treatment with the following individual(s). I understand that I may revoke this permission at any time in writing.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date